

HEALTHCARE PROTOCOL FOR WOMEN WITH HIV/AIDS: PERCEPTIONS OF THE HEALTH TEAM

PROTOCOLO DE ATENÇÃO À SAÚDE DA MULHER COM HIV/AIDS: PERCEPÇÕES DE EQUIPE DE SAÚDE

PROTOCOLO DE LOS CUIDADOS DE SALUD DE LAS MUJERES CON EL VIH/SIDA: LAS PERCEPCIONES DEL EQUIPO DE SALUD

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Objective: to describe the perceptions of a health care team on the healthcare protocol for women living with HIV deployed at the teaching service. **Method:** descriptive study, with a qualitative approach, carried out with 10 members from a regional teaching service of reference for HIV/Aids. The focus group was used for data collection. The participants' statements were submitted to content analysis, thematic modality. **Results:** the themes constructed portrayed the impacts of the protocol in the routine of the health service and the contributions of standardization for the health care of women with HIV/Aids. The execution of the protocol was understood as an ongoing process that requires the involvement of health professionals and reorganization of work processes. **Conclusion:** the protocol implemented in the teaching service appeared as a tool with the potential to facilitate the care with registered women, with possible contributions to the integrality of care provided to women.

Descriptors: Women's Health. HIV Seropositivity. Protocols. Quality of Health Care. Integrality in Health.

Objetivo: descrever as percepções de uma equipe de saúde sobre o protocolo de atenção à saúde das mulheres vivendo com HIV implantado no serviço escola. *Método:* estudo descritivo com abordagem qualitativa, realizado com 10 membros de um serviço escola de referência regional para HIV/Aids. O grupo focal foi utilizado para a coleta de dados. Os depoimentos da(o)s participantes foram submetidos à análise de conteúdo, modalidade temática.

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Resultados: os temas construídos retrataram os impactos do protocolo na rotina do serviço de saúde e as contribuições da padronização para a atenção à saúde da mulher com HIV/Aids. A efetivação do protocolo foi compreendida como um processo contínuo que demanda envolvimento dos profissionais de saúde e reorganização de processos de trabalho. Conclusão: o protocolo implantado no serviço escola apareceu como uma ferramenta com potencial para facilitar o atendimento das mulheres cadastradas, com possíveis contribuições para a integralidade da assistência à mulher.

Descritores: Saúde da Mulher. Soropositividade para HIV. Protocolos. Qualidade da Assistência à Saúde. Integralidade em Saúde.

Objetivo: describir las percepciones de un equipo de atención de la salud sobre el protocolo de atención a la salud de las mujeres que viven con el VIH implementado en el servicio-escuela. Método: se realizó un estudio descriptivo con abordaje cualitativo, con 10 miembros de un servicio-escuela de referencia regional para VIH/SIDA. Se utilizó el grupo de enfoque para la recolección de datos. Los testimonios de los participantes fueron sometidos a análisis de contenido, modalidad temática. Resultados: los temas construidos retrataron el impacto del protocolo en la rutina de los servicios de salud y los aportes de la normalización de la atención de la salud de las mujeres con VIH/SIDA. La realización del protocolo fue entendida como un proceso continuo que requiere la participación de profesionales de la salud y la reorganización de los procesos de trabajo. Conclusión: el protocolo implementado en el servicio-escuela apareció como una herramienta con el potencial de facilitar el cuidado de las mujeres catastradas, con posibles contribuciones a la integralidad de la atención prestada a las mujeres.

Descriptorios: Salud de la Mujer. Seropositividad para VIH. Protocolos. Calidad de la Atención de Salud. Integralidad en Salud.

Introduction

Health care for women living with HIV/Aids presents itself as a delicate area, which requires health professionals have a more enlarged view, geared to their physical, emotional and social needs. HIV/Aids epidemic is not limited to sexual behavior, because other factors, such as gender, living conditions and age and ethnic compositions, are also involved, pointing to its dynamics⁽¹⁾.

Women living with HIV can be seen by health professionals as victims or guilty⁽²⁾. This dichotomous vision indicates that, in health care, creating spaces that enable women's speech becomes imperative⁽³⁾, as well as constructing bonds of trust, to avoid prejudices and stigmas⁽²⁾. Here, it is important to point out that the stigmatization and discriminatory attitudes appear as a barrier that prevents health services from meeting the needs of these women⁽⁴⁾.

Having in view that the interventions of health services can bring benefits for women, as well as contribute to the adherence to antiretroviral therapy⁽³⁾, there emerge potentialities of tools focused on the construction of abilities, for their empowerment⁽⁵⁾ and for the standardization of care⁽⁶⁾ to this segment.

The protocols, technical elements based on scientific evidences⁽⁷⁾, constitute tools for organizing the health service, seeking the standardization of care procedures, optimization of work and patient safety⁽⁶⁾. The literature indicates that the protocols, in the health area, may facilitate the management of care⁽⁸⁾. Therefore, it is important to survey and describe the perceptions of health teams on this theme. In this scenario, a study carried out with members of the health team from a regional teaching service of reference for HIV/Aids pointed out perceptions related to the understanding of protocols as instruments that can result in increased safety and quality care with the user⁽⁸⁾.

Understanding that HIV presents itself as critical⁽³⁾, complex and challenging for the woman demands a closer look of health professionals⁽⁹⁾ at the multidimensional needs of this woman⁽¹⁰⁾, as well as points to the need for protocols capable of guiding the forms of health care⁽⁶⁾.

Regarding the co-responsibility of health professionals with the production and management of a care that meets the assumptions of integrality and humanization⁽¹¹⁾, it is essential to think of the

perception of professionals about the integral care with women with HIV.

The objective of this study was to describe the perceptions of a health care team on the healthcare protocol for women living with HIV deployed at a teaching service.

Method

This is a descriptive study with a qualitative approach, carried out at a teaching service of regional reference for HIV/Aids, in the countryside of the state of Minas Gerais, Brazil. The study was conducted according to the criteria set out in the Consolidated criteria for reporting qualitative research (COREQ)⁽¹²⁾.

The descriptive study enables the characterization of certain phenomenon⁽¹³⁾. The qualitative approach seeks the progressive systematization of knowledge for understanding the studied phenomenon, contributing to the construction of new approaches⁽¹⁴⁾.

In 2018, a healthcare protocol for women living with HIV was developed and implemented at that service. The contents of this protocol were: Women's Mental Health (cognitive changes, depression, bipolar disorder, use of alcohol and other drugs in women living with HIV), Women's Bodily Changes (lipodystrophy, osteoarticular changes related to HIV), Seropositive Women and Sexuality (care with the breast, premenstrual symptoms, delayed menstruation, menstrual delay - LMP>12 weeks -, menstrual delay - discarded pregnancy -, advice on contraception, menopause, complaints of anogenital lesion, care with the vagina - vaginal discharge and cervicitis - cervical cancer -, Use of Dolutegravir in women living with HIV (women of childbearing age who have indication of use of Dolutegravir (dtg), women of childbearing age using Dolutegravir (dtg) and not using effective contraception, women of childbearing age using Dolutegravir (dtg) and using definitive contraception), Pregnancy and Care with the Woman - pregnant women with HIV or with suspicion of pregnancy, pregnancy, breastfeeding - and Women's Support Network.

After a month of deployment, a meeting was held, using the technique of the focus group, with the healthcare team that worked at the service, composed of 10 members, including health professionals and interns with scholarship. The inclusion criteria were: being members acting in the service, being a health professional or student, having direct contact with the women living with HIV enrolled in the service. The exclusion criterion was being absent on the day and time scheduled for the meeting of the focus group.

The focus group, which is used for the collection of qualitative data⁽¹⁵⁾, is a technique geared to the production of data that enables spaces of problematization⁽¹⁶⁾, involvement and interaction of participants⁽¹⁵⁾. Moreover, it can act as a facilitator for discussion and problem-solving, constituting into an opportunity for exploring health actions and studies on deployment of programs⁽¹⁵⁾. In the present study, the aim was to raise the perceptions of the team on the process of elaboration and implementation of the healthcare protocol for women living with HIV and identify possible easiness, difficulties and suggestions in relation to the execution of this instrument at the health-teaching service.

The group participants were 10 members that compose the health service. Of these, 8 (80%) were female and 2 (20%), male. The age ranged from 20 to 50 years old: 4 (40%), from 20 to 30 years, and 6 (60%), from 40 to 50 years. Concerning the professional category, 2 (20%) were nurses, 2 (20%), from the nutrition area (including a nutritionist and an intern of nutrition), 1 (10%) nursing technician, 1 (10%), pharmacist, 1 (10%) medical infectiologist and 3 (30%) were nursing undergraduate students. In relation to the working at the service, 5 (50%) had been working for more than five years, 2 (20%) for more than two years, and 3 (30%) for roughly one year.

The development of the focus group technique requires previous training and qualification of researchers, as well as the flexibility and creativity to plan and conduct the meeting⁽¹⁶⁾, with an emphasis on methodological rigor⁽¹⁵⁾.

Thus, initially, the researchers performed readings and reflections on the technique of the focus group.

In view of the importance of the process of planning and organization for the development of the focus group, the following steps were implemented: awareness of the professionals involved, preparing the environment, implementation of the meeting and analysis of data collected⁽¹⁵⁾. For the awareness, the researchers made contact with members of the health team of the service, inviting them, in person, for participation in the focus group. There was no refusal.

The meeting of the focus group occurred in a room of the health service itself, at a time agreed to meet the needs of the members of the health team. In this environment, the chairs were arranged in a circle, strategy used to promote face-to-face interaction and visual contact between participants⁽¹⁵⁾. The focus group counted with the participation of 12 people (10 team members and two researchers), and lasted approximately 40 minutes.

It is important to highlight the roles played by the moderator and by the observer. The first coordinates the harmonious and participative focus group discussions; the observer plays a role in support⁽¹⁵⁾. To conduct the focus group, a researcher played the role of moderator, and the other, the role of observer.

The moderator received the participants, presented the Informed Consent Form (ICF), provided clarification, explained the content of government documents that served as the basis for formulating the protocol, introduced the guiding questions and led the discussion process. The observer executed the role of support, assisting in the organization of the room and in the gathering of the ICF signed, for example. During the discussions, the observer also made notes, in a field diary, of aspects that are important for understanding the object under study, observing the non-verbal communication of participants when reporting their opinions.

In the focus group, the guiding questions motivate the discussion process⁽¹⁵⁾. Therefore, a

guide comprising the guiding questions used to conduct the group was drawn up: "What is the easiness of having a protocol of standards for the service?"; "What are the difficulties to adapt the protocol to the reality of the service?"; "What did you think of the protocol regarding its structure, addressed content?"

The participants' statements were audio recorded, transcribed and analyzed by means of the content analysis, thematic modality, which seeks to identify meaning cores that compose a particular communication, with meanings for the individual⁽¹⁴⁾. The transcribed data were not presented to the study participants.

In this article, the participants' identification will be made by the letter P followed by the serial number of the interview.

The research project was approved by the Research Ethics Committee (REC) of the University of the State of Minas Gerais (UEMG), Opinion n. 2.333.413.

Results

After analyzing the content of the participants' statements, two themes emerged: the standardization of the health care with women: impacts of the protocol in the service routine, and the contributions of standardization for the health care with women with HIV/Aids:

Standardization of the health care with women: impacts of the protocol in the service routine

The participants' reports pointed to the potential of the protocol, seeking improvements in the health care with women with HIV. For this reason, there emerged the understanding of the need for restructuring certain work processes of the healthcare team.

The following report emphasizes the importance of preparing a protocol consistent with the reality and the needs of the service:

The protocol was prepared according to our reality, meeting the needs of the service in the area of women's health care. I can only thank for the execution, because the implemented projects help a

lot in the service management, resulting in learning for you [students] and in a valuable contribution for us [professionals]. (P1).

The following reports emphasize the usefulness of the protocol for the care provided by all members of the team, professionals and students:

Personally, I find the protocol great. We are working with it in the service routine. The protocol is going to be very useful for new professionals and students who are going to work here, because they will have a structured and detailed protocol in this area. (P1).

The protocol fits the reality of our service. The turnover of students in here has been increasing a lot, of both scholars as volunteers, and it [the protocol] will be the basis for the care with this clientele, because, for the service work, all professionals have to speak the same content. For professionals that have been there for a longer time, the protocol content is routine, but for someone new, it's a lot of information. Besides, each case has to be analyzed individually, so that we manage to achieve integral care. So, for those professionals that have been there for a short period, or for future professionals, it's going to be a reference to follow, contributing to the engagement of the team in the area, as well as for long-term professionals. (P2).

The recognition of the need for continuity in the deployment and use process of the protocol can be observed in the reports:

The creation of the protocol is very valid. It's going to be a legacy we will follow in the service. Even if its elaboration and implementation end up, it will remain in the care with women living with HIV. (P4).

The team must contribute to its deployment. Although it is bureaucratic and has barriers, it's worthy our efforts. (P7).

Despite the recognition of the importance of the protocol drawn up, some difficulties for executing this tool were reported, with emphasis on the woman's attendance at the health service and on the creation of bond with the team:

The greatest difficult we find to execute the protocol is the woman's adberence to the service, because they feel asbamed of the situation they are experiencing and want to ignore HIV. A solution would be creating bonds with the women, to get all information on their life, demanding special attention from our team at this point. (P5).

The need for restructuring some work processes of the team also emerged in the reports:

We're executing a reorganization of the team to provide the service to women. It's requiring time and a lot of work from the team, but it's working out. We've already begun to meet the clients according to the protocol and it's working out well. (P10).

An alternative we propose, to facilitate the execution of the integral service, is to fit some appointments of women to the service, on the same day, once they'll be already here. (P8).

With the standardization of assistance, the protocol systematizes the care flow for the service, which defines the role of each professional in the management of the care with women:

It made everything easier for each one of us know better other professionals' work and their relation with our own work, expanding the understanding about continuity of attention to the woman. (P6).

It became clearer for us, with the implementation of the protocol, about the nurse's role to carry out and follow up the case, during the service flow by each professional of the team, and about the importance of this careful execution, in addition to the commitment of each professional involved, so that there are no gaps in the follow-up of women at the service. (P3).

The contributions of standardization for the health care with women with HIV/Aids

The perceptions of the health team point to the contributions derived from the standardization of health care of women living with HIV/Aids. There is the understanding that the healthcare professional's gaze should be expanded, turning to the different dimensions and needs of women:

I'm returning from a congress now, and one of the most prevalent discussions is the issue that people with HIV currently live a lot longer, have longer lives, which increases the diseases associated with HIV, and we [professionals] will have to learn to live with this situation. So, the protocol comes according to the needs of this population. (P1).

Women are very vulnerable in society, so a protocol so dedicated to the knowledge is important. (P7).

Thus, the participants considered the potential of the protocol for contributions directed to the integrality of the health care with women living with HIV/Aids:

The protocol aims entirely at women, collaborating to knowing them better, besides HIV, giving more autonomy for service professionals to intervene. (P3).

The protocol will assist in clinical tests, changes that occur in women. Thereby, evaluating their adberence to treatment and the effects of medication, contributing to improving the health of these women. (P6).

In addition, the participants recognized the contributions of an integral care to the problem-solving care provided by the service, with positive repercussions on women's health:

One of the advantages is providing women with integral care, thus improving their health to continue facing HIV. (P5).

The protocol made the service uniform and specific to the singularities of women, thus providing greater resolution concerning several cases. (P9).

Regarding the integrality offered in care, there occurred humanization of the healthcare professional in relation to the woman, as shown by the following report:

From the protocol, we begin to see women as a whole, and this demands more attention from us [health professionals], generating humanization in the care with women, since we know each user of the service with their specificities and needs. That's great! (P2).

The support network that exists in the service, systematized with the network of attention of municipalities, contributes to the quality of the final care provided to users, according to the following reports:

Another thing that already existed, but was systematized with the implementation of the protocol was the relationship of the care provided in the service with the other services of the care network of the municipalities, such as maternity units, family health, urgency and emergency units and the Center for Reference and Care for Women in Situation of Violence of Passos. (P10).

It improved our communication with these services and referral and counter-referral strategies. This ends up impacting the quality of final care provided to women living with HIV. (P4).

Discussion

The study participants reported easiness and difficulties in the standardization of care with women with HIV at a health service. The recognition of the potential of the tool developed for organizing work processes points to the understanding that protocols are configured as dynamic instruments of the planning process⁽¹¹⁾ in the services of attention to women with HIV.

Thus, health professionals must recognize the potential use of protocols⁽¹¹⁾. In the present study, the process of implementation of the

protocol of attention to health of women living with HIV highlighted the need for reorganization of the health service for the care with women, according to their particularities. In this way, health professionals must identify the real needs of women's health⁽¹⁷⁾, to organize a care consistent with the reality experienced and with the demands presented.

The organization of a care detached from the woman's needs may contribute to the occurrence of gaps in attention to women with HIV, such as those related to sexual and reproductive health⁽¹⁸⁾. In this scenario, the development of health promotion actions, seeking women's empowerment⁽¹⁹⁾, should also be encouraged. Therefore, the attention to the woman with HIV should seek the promotion of health and autonomy⁽¹⁸⁾.

The participants' reports show that the care standardization contributed to the integral care, with possible repercussions on the problem-solving healthcare with women living with HIV/Aids. There is recognition that the completeness can be translated into the access to problem-solving actions, consistent with the health needs, which value the multidimensionality of women⁽¹⁹⁾. Authors⁽²⁰⁾ emphasize that people with HIV/Aids have the right to an integral assistance, aimed at assurance of access, human rights and real health needs.

In relation to the creation of bonds between women living with HIV and the health professional, there is a need to establish trust. The creation of bonds becomes important in the scenario of the integrality of care⁽¹⁹⁾, because it allows for a rapprochement with the reality experienced by this woman and her care needs.

The services of attention to women with HIV should offer a quality assistance⁽²¹⁾. Considering that this study refers to the reality of a reference service for HIV/Aids, the interlocution with other points in the care network to the woman, highlighting Primary Health Care (PHC) services, may contribute to the guarantee of integrality of care. In this direction, it becomes necessary to problematize the role played by these services

in the care with women with HIV, important partners for their follow-up.

In the organization of PHC services, the needs and expectations of the population should be considered, seeking the access and quality of care⁽²⁰⁾. In this way, it is important to emphasize that, in the routine of health services, protocols, as tools for care management, may have the potential to contribute to the organization of work processes and support health professionals' actions⁽⁸⁾. Nevertheless, a study⁽⁸⁾ highlights that gaps in the engagement of the health team can undermine the process of standardization of care at the service.

Therefore, PHC appears as a health promoter for the assigned population⁽²¹⁾, which may assume a prominent role in the development of actions geared to users with HIV⁽²⁰⁾. Therefore, the care shared between the different services, PHC and specialized care from the healthcare network⁽²¹⁾, appears as an opportunity of integrality in the care with women with HIV. They can experience different situations of vulnerability, which shows the importance of a sensitive and humanized listening from healthcare professionals during the moments of assistance⁽¹⁸⁾. The reports of the study participants reinforce the need for a care directed to the different needs of women's health, not restricted to the biological aspects, which indicates the importance of expanding the gaze of the health care professional on the different scenarios of a woman's life⁽¹⁹⁾.

Social issues related to stigma, for example, was another point raised by the study participants. Concerning the fact that the experience of fears relating to the social stigma still presents itself as a reality for women with HIV⁽²²⁾, the actions of health professionals should be directed to the assurance of rights. The behaviors and procedures adopted by health professionals, such as those related to respect and confidentiality, may reflect the continuity of care directed to this woman⁽²²⁾.

In a study⁽²³⁾, the findings suggested, in addition to meeting the needs of mental health and the stigma, the need to develop interventions to reduce it, guiding the community and spreading the disease prevention among women

living with HIV. The interventions to reduce HIV-related stigma aim to mitigate its internalized effects. One of the strategies adopted is the care humanization for women by health professionals, creating bonds⁽²⁴⁾.

Women need to be motivated by health teams to talk and discuss openly about their situation, in an attempt to destigmatize the disease. Thus, they need to learn how to increase their knowledge about the health problem, become independent in relation to their health and have control over their decisions. Therefore, health teams should provide care and support according to their needs⁽²⁵⁾.

It is important to emphasize that, many times, the attitudes of health professionals may be intertwined by judgments, which indicates the need for continuing education strategies^(2,25) directed to coping with the stigma, in order to contribute to expanding the access of seropositive women to health services⁽³⁾.

Furthermore, issues relating to secrecy and confidentiality must also be considered⁽²⁰⁾, with contributions to the establishment and strengthening of the bond between the woman with HIV and the professionals of health teams. A study⁽²²⁾ points out that aspects related to the quality of care received and the assurance of integrality may affect care continuity. This aspect could be observed in a literature review⁽²⁵⁾, which found that women inserted into support groups decreased social isolation and feelings of shame, increased network of friends, created relations of mutual empathy, improved self-care behaviors and decreased the risk of re-exposure to HIV.

After implementing the healthcare protocol for women living with HIV, it must be constantly assessed and updated. The processes of assessment, in the health area, emerge as mechanisms intrinsically tied to planning and decision-making⁽²¹⁾, which affects the quality of care provided, in particular concerning women with HIV.

This study showed the potential of organization of care with women with HIV, considering them as a unique and multidimensional subject. Thus, the reception

of women and the recognition of the social determinants of health-disease process must permeate the care actions⁽¹⁹⁾ at different health services. The mode of organization of these services should not act as a barrier to the assurance of the right to health⁽²⁰⁾. Thus, strategies should be built, seeking to strengthen the care with women with HIV⁽²¹⁾.

A limitation of the study was that the research did not address the perception of women living with HIV, enrolled in the service, on the care systematization occurred after implementing the protocol, thus suggesting new studies that advance in knowledge about these women's point of view about the care received.

Conclusion

The healthcare protocol for women with HIV was understood as a tool with the potential to facilitate the care with women enrolled at the teaching health service. Its deployment was understood as an ongoing process that requires the engagement of health professionals and reorganization of work processes. The perceptions of the health team were also linked to the potential of standardization for an integral care with women, pointing to opportunities for improving the quality and effectiveness of the service.

In this sense, this study shall contribute to expanding the gaze on the different forms of organization of care with women with HIV/Aids, to emphasizing the importance of reorganizing health services based on government documents and the need to build an integral and longitudinal care with this woman.

Collaborations:

1 – conception, design, analysis and interpretation of data: Jeniffer Stephanie Marques Hilário, Sabrina Pereira Lima, Jaqueline Silva Santos, Policardo Gonçalves Silva, Geilton Xavier de Matos and Raquel Dully Andrade;

2 – writing of the article and relevant critical review of the intellectual content: Jeniffer

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3 – final approval of the version to be published: Jeniffer Stephanie Marques Hilário, Sabrina Pereira Lima, Jaqueline Silva Santos, Policardo Gonçalves Silva, Geilton Xavier de Matos and Raquel Dully Andrade.

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