‘Repeat offenders’ in care, but with no right to prevention: An analysis of the availability of post-exposure prophylaxis for HIV in Porto Alegre, Brazil

Reincidentes en el cuidado, pero sin derecho a la prevención: un análisis de la oferta de la profilaxis posexposición sexual al VIH en Porto Alegre, Brasil

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ABSTRACT This study seeks to identify challenges in the implementation of post-exposure prophylaxis for HIV, based on an analysis of actions taken by healthcare professionals in the state-run health sector in Porto Alegre, Brazil. Based on a qualitative approach that included ethnographic observations and in-depth interviews, we found that contextual, institutional, and individual factors represented challenges to the implementation of post-exposure prophylaxis for HIV. Barriers to implementation included the historical context structuring healthcare services and practices, the lack of training and/or continued education in health, and certain attitudes on the part of healthcare professionals (ideas regarding both the strategy itself as well as the individuals that seek PEP). We conclude that there is a need for greater attention to specialized services for STI/HIV/AIDS as well as the professionals that provide these services, in order to guarantee greater effective access to this strategy at the local level.
KEY WORDS Post-Exposure Prophylaxis; Sexually Transmitted Diseases; HIV; Brazil.

RESUMEN Buscamos identificar los desafíos para la implementación de la profilaxis posexposición sexual al VIH, a partir de analizar el accionar de las y los profesionales de la salud en un servicio de salud pública en Porto Alegre, Rio Grande do Sul, Brasil. Desde un enfoque cualitativo, con técnicas de observación etnográfica y entrevistas en profundidad, se encontró que los factores contextuales, organizacionales e individuales eran desafíos para implementar la profilaxis posexposición sexual al VIH. Las barreras para su implementación incluyeron el contexto histórico de la estructuración y la actuación del servicio, la falta de capacitación y/o educación continua en salud, y las concepciones de las y los profesionales de la salud (ideas sobre la estrategia en sí, y sobre las personas que buscan PEP). Se concluye que existe la necesidad de mayor atención al universo de servicios especializados en ITS/VIH/sida y a las y los profesionales que componen estos servicios, a fin de garantizar una mayor efectividad en el acceso a la estrategia a nivel local.
PALABRAS CLAVES Profilaxis Posexposición; Infecciones de Transmisión Sexual; VIH; Brasil.

INTRODUCTION

Post-exposure prophylaxis for consensual sexual exposure to HIV – sexual PEP or simply PEP – is a strategy to prevent HIV infection that involves taking antiretroviral medications for 28 days consecutively on the part of individuals who do not live with HIV and have had consensual, unprotected sex in the last 72 hours due to failure or non-use of HIV prevention methods. [1] PEP is included in the so called "combination HIV prevention" program, an international policy aimed at facing the HIV/AIDS epidemic, supported by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) since 2010.[2] Broadly speaking, combination prevention constitutes a shift in the paradigm in HIV prevention, since it groups together all of the prevention methods with a verified effectiveness. It gained greater relevance with the implementation of prevention methods that use antiretroviral medications as a way to prevent HIV transmission (in the case of individuals who are infected with the virus) and acquisition (in the case of individuals who are not infected with HIV). This new paradigm helped to progress on HIV prevention strategies and other sexually transmitted infections (STIs), apart from the promotion of condom use, which marked the first decades in dealing with the epidemic.[1,3,4] At the same time, it helped individuals to choose the method that best suits their context and sexual needs. Criticisms on combination HIV prevention focus on the little importance given to structural interventions and the predominance of methods for HIV prevention and/or treatment that use antiretroviral medications, which has been considered a biomedicalization of HIV prevention.[5]

Combination HIV prevention is also part of the UNAIDS 90-90-90 target, through which the UN member states committed themselves to reach, by year 2020, ninety percent of people diagnosed with HIV, ninety percent of people provided with antiretroviral therapy (ART) and, out of these people, ninety percent who have undetectable viral load, which avoids HIV transmission. It is estimated that if the 90-90-90 target is reached in 2020, the end of the HIV epidemic would be announced by 2030. While science and biomedical discourses confirm that the "end of AIDS" is near, they remark that the complexity of the epidemic and the barriers to health care access constitute a challenge for the accomplishment of this goal, presenting the "end of AIDS" as a rhetorical reality rather than a reality to be materialized.[6]

In accordance with the international recommendations, new strategies were implemented in Brazil, among which pre-exposure and post-exposure prophylaxis are included. Such strategies are challenging the Brazilian Unified Health System [Sistema Único de Saúde - SUS], considering that the structure of health care services do not always adjust to the guidelines of clinical protocols. [7,8] In Brazil, recommendations on the prophylactic use of antiretroviral medications, in situations of potential exposure to HIV, were adopted in the 1990s, and only for cases of occupational accidents with biological materials among health care professionals (except for cases of vertical transmission). During that decade, women and female adolescents, victims of sexual violence, were included in the recommendation. In 2010, prophylaxis strategies began to cover situations of HIV exposure in consensual sexual activities. Only in 2015, recommendations of prophylaxis merged into a single document.[1]

The demand for the use of PEP increased, mainly, between individuals who identify as *gay* and men who have sex with other men.[9,10,11,12] One of the most remarkable fears regarding PEP is the possibility of causing an increase in the sexual practices with risk for HIV infection and the repeated use of the strategy.[13] Based on the literature reviewed, it is not possible yet to confirm that PEP causes disinhibition in the use of the traditional prevention methods, such as condoms.[11,14] The non-use of the traditional prevention methods has been pointed out by international[15] and national[16] studies as a social phenomenon, regardless of the knowledge that subjects have on the existing ways to prevent HIV. In order to analyze the potential increase in the search for PEP and PrEP prevention strategies, it is necessary to conduct even more research studies on the relation of this increase with the disinhibition in the use of the traditional prevention methods.

In this sense, a research study on the relation between the use of PEP and sexual behaviors with

risk for HIV infection, in a cohort of homosexual men conducted in Sydney, Australia, concluded that adopting the strategy does not increase sexual practices for HIV infection.[17] Another research study, conducted in Rio de Janeiro, Brazil, also came to the conclusion that there was not a relation between the increase of sexual practices with risk for HIV infection and the adoption of post-exposure prevention with antiretrovirals. Therefore, it is not possible to confirm that PEP causes an increase in HIV vulnerability.[18]

In the current context where new prevention strategies based on antiretroviral medications are expanding, it is important to analyze the challenges regarding the availability of PEP at the local level. Evaluating the implementation of a public policy at the local level in those services that provide health care directly to the beneficiaries of the policy is a study that involves the "street-level bureaucracy" or "front line"[19] category of the public policies. On the *front line*, health care professionals relate to the population constantly and directly through a process where policy instruments are transferred to the local sphere. Studies on the implementation of public policies observe that the *front line* connects the set of perceptions, actions and interactions of health care workers in health care institutions as well as the context in which they are introduced.[19,20,21,22]

This paper aims to identify the challenges in the implementation of PEP for HIV, by analyzing the actions taken by health care professionals in specialized public services for STI/HIV/AIDS in Porto Alegre, Rio Grande do Sul, Brasil. This approach seeks to identify how these professionals are using their abilities to understand points of view, perform tasks and achieve the goals presented by public policies. From this perspective, the research question is: what are the challenges in the scope of implementation of PEP and how can they affect people's access to this strategy?

There are still just a few qualitative research studies focused on the implementation of a program and the tasks that health care professionals perform in the health sector in Brazil. The data here presented comes from a research study entitled *A efetividade da profilaxia da transmissão do HIV pós-exposição sexual consensual (PEP), do uso combinado dos métodos preventivos contra a infecção pelo HIV e da profilaxia pré-exposição sexual (PrEP), em serviços públicos brasileiros* [The effectiveness of post-exposure prophylaxis (PEP) for consensual sexual exposure to HIV transmission, of the combined use of prevention methods for HIV infection and of pre-exposure prophylaxis (PrEP) in the Brazilian state-run health sector] or, simply, *Combina Project*, funded by the Brazilian Ministry of Health (027941/2012) and the National Council for Scientific and Technological Development [CNPq - *Conselho Nacional de Desenvolvimento Científico e Tecnológico*] (14/2014). The Combina Project has two epidemiologic studies and a qualitative one. The analysis conducted in this paper is a fragment taken from the qualitative element.

METHODOLOGY

This paper is a fragment taken from a wider research study based on a qualitative approach, included in the Combina Project, a multi-centric research study conducted in five Brazilian cities.[23,24] The "case study" research design was conducted in the city of Porto Alegre due to the fact that, among the other cities of the project, this city showed favorable conditions for conducting a research study of this kind. On the one hand, Porto Alegre has both a high HIV prevalence and incidence and a considerable magnitude of mortality[25] from AIDS, leading it to be known as the "capital city of AIDS."[26] On the other hand, the city also presented the structural and organizational conditions for the Specialized Assistance Services for STI/HIV/AIDS. The research study is composed of two groups: one in charge of the counseling and testing center and, the other one, in charge of the specialized ambulatory care. In addition, the participation of such services in the multi-centric research project was the result of an agreement between the coordination of the Combina project and the Municipal Health Secretariat of Porto Alegre. The latter suggested the incorporation of these services due to the great number of patients who are provided with health care, the years it has been functioning (more than a decade) and for having implemented a protocol with PEP availability which was in force at the time. The fieldwork was conducted for eight months, between 2015 and 2016.

In the observational research method, based on an ethnographic approach, a semi-structured interview guide was implemented to produce empirical information. Following this guide, the areas of the services, reception areas where people seek PEP, waiting rooms, examing rooms and the areas where health care professionals interacted (meeting room and kitchen) were observed. Situations like patient reception, appointments, meetings and health care professionals' rest periods were observed. In such contexts and situations, the observation focused on the relations of health care professionals with each other and with individuals, seeking to characterize the decision-making processes of healthcare professionals regarding PEP.

The purpose of the observation guides was to learn about the PEP healthcare organization in the services and to gain knowledge on the perception and everyday practices of health care professionals towards PEP. In addition to the consent of the services to take part in the widest research conducted by the Municipal Health Secretariat, the entrance into the field was arranged by coordinating the services and the researcher in charge of the study. This ethnographic observation was not carried out by a healthcare professional. In some way, this confirmed a place of double estrangement: for him, in his capacity as observer, and for the team, because they included a person who "did not belong to the health care system." PEP, still at the implementation stage, was a novelty for both the team and the researcher. Estrangement and novelty were the starting points for building up a relationship of trust and mutual understanding between the researcher and the team. Being introduced into the specialized services for STI/HIV/AIDS helped the researcher to observe everyday life of health care professionals, the flow of people who seek PEP, team meetings, interactions among those being observed, and other activities.

Besides observations registered in field notes, empirical data was also collected through in-depth interviews. This technique was chosen to enable us to understand, using a predefined and flexible guide, the values and meanings that observed subjects give to their personal and professional experiences.[27] In the interviews, topics such as their knowledge about PEP were explored. The guide also included sources for information and continued education, their views on different people who sought the health services and their clinical situations, and how interactions and counseling of professionals concerning risk-reducing strategies developed. In such interviews, the professional staff and the health services management were summoned. Among the participants, three doctors and a nursing technician refused to take part in the interviews. Except for the nursing technician, the rest of the professionals who refused to be interviewed were not involved directly, or indirectly, with PEP.

Those who agreed to the interview were in closer contact with the implementation of the strategy in the service and had a greater commitment to it. Their identities were preserved at all times, and their names have been replaced to maintain confidentiality. We have chosen to not reveal occupation, sex, gender, age, or any other characteristic of the interviewees, so as to prevent professionals from being identified since the city of Porto Alegre has few specialized services for HIV. Therefore, in some parts of the text the generic masculine was chosen.

In total, 15 interviews were conducted with health care professionals, including a doctor, two nurses, a social work assistant, three psychologists, a pharmacist, three nursing technicians, a nursing auxiliary, an administrative assistant and two residents in collective health. All of them, except for the residents, had been working in the health sector since 2010, when PEP was adopted. One of the health care professionals acted as manager of the services. The interviews were recorded and transcribed, and the observations were documented in a field diary. All of the people involved were requested to sign the informed consent form. The research protocol was approved by the School of Medicine Research Ethics Commission of Universidade de São Paulo (CAAE 34145314.5.1001.0065) and the Municipal Health Secretariat of Porto Alegre (CAAE 34145314.5.3001.5338). The analysis of the interviews and observations was conducted using NVIVO software. After a first reading of the empirical material, an analysis of the contents was done and, subsequently, the central axes for conducting this analysis were identified, supported by the theoretical framework used in this paper.

The central axes of the analysis were: 1) the influence of the context over the work processes at the local level, 2) the organizational dynamics of the services and 3) the individual perceptions of health care professionals.

RESULTS AND DISCUSSION

Firstly, we briefly present the characteristics of the empirical universe where the ethnographic observations were carried out. Then, the elements that may have influence on the availability of PEP in the services under study are identified. Such services are located in a region that has undergone social problems related to access to housing, basic sanitation and increasing urban violence. As the bibliography shows, such factors may be manifested in the health-disease process,[28] impacting the production of inequities and vulnerabilities of individuals – and, to some extent, on work processes – that affect health care professionals who work in the territory under study.

From the point of view of the organizational environment, the services are composed of the counseling and testing center and the ambulatory care services, both created in the 1990s. In their early years, these centers were autonomous and each one organized their own work processes. In 2012, both health care services and their management began to be unified, in order to work together in the specialized health care services for STI/HIV/AIDS. In spite of the unification, both services remained, in practice, as different units from the organizational point of view: the patient flow and teams were different, although they were in the same facility. When the fieldwork was conducted, both were under the same management, a service coordinator who was responsible for technically aligning medical care and testing, which included joint meetings where both the counseling and testing center team and the ambulatory care services team took part. Both teams were different in profile and independent from one another: proceedings and everyday practice in each team were specific for their own unit.

The counseling and testing center was in charge of conducting conventional tests – exclusively performed with Elisa tests and confirmatory tests – pre-test and post-test counseling, apart from accompanying people who made use of these services. Psychosocial care in the counseling and testing center lasted, on average, one hour (it was longer than the average duration of the counseling at the ambulatory care services for situations involving PEP). The availability of conventional tests was ensured by spontaneous demand and, before or after counseling, individuals were referred to the laboratory and the results came back, on average, after 15 business days. The results were delivered to individuals in person, with psychosocial and post-counseling care. At the time of this research, the counseling and testing center did not offer rapid tests for everyone, and its use was restricted to those cases where PEP was requested by the patient.

The ambulatory care services concentrated assistance services and focused on the treatment and accompaniment of people who live with HIV. It did not offer neither rapid nor conventional tests by spontaneous demand. Whoever wanted to get tested for HIV and other STIs in the ambulatory care center, with no prior link to that center, was referred to a more complex primary health care unit and not to the counseling and testing center. According to the interviewees, referring people to primary health care unit followed a command given by the local administration, based on orientations of the Ministry of Health.[29] The availability of PEP was exclusively attributed to the ambulatory care services since the implementation of the strategy in 2010 and has not been modified with the unification of the health services management units.

The dynamics of implementing PEP

Providing care for people who experienced a situation of sexual exposure to HIV is complex. In the specialized health care services for STI/HIV/AIDS, it was noted that people were admitted when, in the reception area, they would volunteer information about a situation of sexual exposure. At that time, the health care professionals from the reception area arranged a first medical consultation for the use of PEP.

Only two nursing professionals were in charge of providing care for HIV exposure situations in

consensual sexual activities and were responsible for evaluating the risk of infection through rapid tests for HIV and syphilis, counseling and recommending the use of PEP. Welcoming, evaluating and counseling individuals was a process that lasted 20 minutes in the ambulatory care center. If the situation of exposure was considered a significant risk for HIV infection, the use of PEP was offered to the user. This prescription came along with information about side effects, drug interactions and combinations with other substances.

Even when PEP was indicated, the decision of using it or not was made by the patient. If the health service user chose to get PEP, a nursing professional would go to the doctor's office to discuss the case, and get a prescription for antiretroviral medications and laboratory tests to monitor the use of PEP. During fieldwork, it was observed that the situations of sexual exposure were always evaluated by the nursing staff and that there was no direct interaction between patients and the members of the medical staff. The moment in which users of the service expressed their decision of taking PEP, and the nursing professional went to the doctor's office, users underwent a rapid test for HIV and syphilis. The results of this test were ready in approximately 20 minutes. While waiting for the results and the return of the nursing staff, the patient would express to the researcher a feeling of anxiety and guilt due to the potential situation of having been sexually exposed to HIV.

When the nursing professional returned to the doctor's office, the user was informed about the rapid test results. If someone tested positive for HIV, he or she was referred to a primary care unit to start the antiretroviral treatment in the health care center closest to his or her domicile, a treatment that could take days or even months in Porto Alegre. If the rapid test results tested negative for HIV, the user would receive counseling on the use of antiretroviral medications. Furthermore, users would be given an explanation of the medical care services, if needed. Lastly, the healthcare professional would make a new appointment within 28 days. It was observed that nursing professionals emphasized the importance of attending the scheduled appointment, mainly to get tested with a new rapid test and discard any possibility of HIV infection.

In the case of the counseling and testing center, although it did not offer PEP, potential situations eligible for PEP were observed. The researcher observed two flows by which the user in a situation of sexual exposure could be identified in the counseling and testing center: the first flow, in the reception area and, the second one, while providing psychosocial care. According to professionals working in the reception sector, when individuals described situations of sexual exposure, they were immediately referred to the ambulatory care center. The second flow was detected when psychosocial care was provided by professional counselors. Identifying those cases was difficult and it only happened when the user manifested to the professional a recent situation of sexual exposure. Despite the procedure established by the counseling and testing center, we observed more than one situation during fieldwork in which, within the framework of pre-test and post-test counseling, the narrative of a recent risk exposure to HIV where PEP was prescribed but was not referred to the ambulatory care center.

Interviews made with health care professionals who work in the counseling and testing center revealed that they regarded the unit as a service in itself and not as a part of a specialized service. Therefore, they considered that its functioning was independent from the ambulatory care center. At the same time, there was not a defined protocol that organized the patient flow between both centers. Given this situation, there were no initiatives from the counseling and testing center to actively look for those individuals who may benefit from PEP. Another aspect to be remarked is the instrument used by counselors to provide psychosocial care. It was a standardized questionnaire seeking to gather the patient's personal information and to know the reason why he or her had sought an HIV test. The questionnaire focused on gathering information about the risk of sexual exposures that had not occurred within the last 72 hours but rather in the last 12 months. Thus, this outdated instrument did not contribute to analyzing situations of recent exposure to HIV, thus hindering access to prophylaxis.

Incorporation and unawareness

The professionals who were interviewed vaguely remembered the implementation of PEP to the routine of the counseling and testing center and to the ambulatory care services. The few narratives about this process came from people who worked in the ambulatory care center. They considered the implementation of PEP as a process conducted "from top to bottom," as a strategy that depended on the local universe of medical services, without receiving training or continued education. In relation to this, the interviewees of the ambulatory care center expressed that they did not remember that PEP training was delivered at the time of its implementation in 2010. Nor did they remember having received continued education on new prevention methods based on the use of antiretroviral medications. In the counseling and testing center similar narratives were observed.

In the process of implementing public policies, Sabatier pointed out the existence of two main models: the *top-down* approach and the *bottom-up* approach.[30] The *top-down* approach is based on a technical, functionalist and managerial perspective of the decision-making process in the political sphere, whereas the *bottom-up* approach seeks to promote a process of self-organization and participation of actors who deal directly with public matters, considered essential for making decisions. In this study, the interviewees' perceptions characterize a *top-down* implementation of PEP, which complicated the incorporation of the strategy in the services under study.

The initial problems of implementation may have had an effect on the decision of restricting the knowledge about PEP to a few professionals. The technical and regulatory knowledge about PEP was centralized in the nurses of the ambulatory care center. Medical services managers and colleagues did not motivate these professionals to share the knowledge that they had about the protocols of PEP. The lack or little knowledge about the regulatory level of an action, strategy or program is mentioned in the literature as detrimental for the process of implementing public policies.[31]

Additionally, the lack of PEP training or continued education may contribute to the creation of individual notions about the strategy and may have an influence on the work processes and the purpose of the preventive measure. Although the professionals interviewed admitted the importance of PEP, they were reluctant about the changes that new strategies (specially PEP and PrEP) may cause in the public policies of HIV/AIDS, and that reluctance, in turn, may constitute a barrier to the implementation of the strategy.

Repeat offenders

The importance of the PEP strategy was acknowledged by most of the interviewees, although the use of the method was limited to a way of rectifying situations which are unwanted or, ideally, unexpected. This conception differs from the use of the method as a prevention strategy, in order to be included in the individuals' practices depending on their needs. Furthermore, professionals brought into question the effectiveness and the level of protection provided by the method, and they warned about the possibility of PEP failure. Thus, PEP is considered as an exceptional measure, for situations where HIV prevention fails:

> [PEP] *is valid because accidents really happen. But, sometimes, you see there are people who are repeat offenders. They come more than once. Ah, they come two, three, four times. So, you see that these people, who even know about the risks, they will take the risk, you know? And there will come a time when it may not work. They start taking the medication, taking the medication and what if one day it doesn't work...? They take too much risk, but anyway I think it is valid to have that assurance.* (Interview, August 2015)

In this interview, it is possible to notice the concerns about the repeated use of the strategy. Health care professionals, generally, worried about the fact that the user would choose to have unprotected sex, even when facing a potential risk of becoming infected with HIV. In other words, professionals feared the trivialization of the strategy. Again, it should be emphasized that existing studies do not present a relation between the use of PEP and the fact of leaving other HIV prevention methods behind.[32]

The repeated use of the strategy was found in several narratives as the user's lack of care for sexual health, and as an indicator of leaving behind traditional strategies for HIV prevention (such as the use of condoms and lubricant gel). Such a situation could be interpreted by professionals as a form of coping with the risk and, in this sense, as a form of taking care of the user's own sexual health (although it is not the form of care that they propose or consider ideal). This research study is not focused on how many users were in fact making a repeated use of PEP. What is emphasized is that some of the professionals who worked in the ambulatory care center had a deeply rooted idea that there were users who frequently returned to the service. This idea was not confirmed by professionals from the counseling and testing center due to the fact that they did not provide health care, in practice, to individuals who take PEP.

In the following situation, the interviewee describes how the partner of a person living with HIV uses the strategy repeatedly:

> *There are some* [...] *situations that become repetitive. There is a girl who came here maybe about six, seven times, I think. Just like this, a month she would come, a month she wouldn't come, practically. She was married and her husband was infected with HIV and, in her case, she experienced condom breakages. The first time, we provided her with guidance and everything: "look, he has an undetectable viral load, you are going to take the medication."* [...] *Soon after, again. "You don't know how to use condoms, do you apply lubricant on them the right way?" That time we explained to her... Third time, again. There's something wrong here! She would be a candidate for PrEP!* (Interview, August 2015)

It should be remarked that PrEP, at the time of conducting the fieldwork, was not yet made available in SUS. In the narrative above, what is also surprising is that PEP is prescribed when someone has sexual intercourse with a partner who lives with HIV and has an undetectable viral load. The estimated risk for HIV transmission in such cases is insignificant and insufficient for prescribing PEP or PrEP. Given this situation, UNAIDS launched in 2017 the campaign "Undetectable = Untransmittable," with the purpose of providing health service managers, professionals and the community at large with information about the non-transmissibility of HIV when the viral load is undetectable, and about the importance of the treatment as a way of preventing HIV infection.[33]

Moreover, according to the narrative above, condom breakage is seen as a sign that the user makes a wrong or even careless use of the product. It is possible to note that, on some occasions, professionals brought into question the veracity of the narratives about condom breakage. However, condom breakage may occur for various reasons such as poor quality or improper use of the product. Therefore, it should not seem strange that the reason for requesting PEP is due to failure of the prevention method.

Perceptions on the repeated use of PEP and the idea of not using condoms or using them incorrectly hold meanings about subjects and their sexual practices. This is the case of the notion of repeat offenders, an emic category observed in the interviewees' discourses:

> What people see, I think that is something that may lead to rumors. There are people who come several times. Subjects who are *repeat offenders*. We see that very often: "So-and-so! Back here again?" We see it happen ... Because this is what normally happens nowadays: you are scared to death to go out to the nightclub and even without taking a risk, you come here sweating and with your heart in your mouth... That type of activity [clubbing] is not for you, is it? (Interview, August 2015)

According to the interviewees, repeat offenders may have two sides: one is that of being *irresponsible* subjects, since they consciously continue to incur potential sexual exposure to HIV several times, thus causing overloads in the health care services every time they return for PEP. The idea that these subjects continue to take risks is what makes interviewees see them as *irresponsible*, even if they have been to the service for medical care and prevention methods that they cannot

buy in a pharmacy nor get in a private service. Another side of the repeat offenders is that of the subject who worries excessively: not only about the risk of becoming infected with HIV but also about the stigma related to HIV and AIDS. Such *worried* subjects, in some cases, are considered by health care professionals as *not eligible for the use of the method*, because they do not publicly assume their practices, which means another way of punishment for them.

Non-urgent prevention

PEP constitutes a medical emergency, according to the established protocol.[1] In Porto Alegre, PEP is available at the specialized services for STI/HIV/AIDS and at emergency rooms and urgent care centers. The implementation of PEP in such services was not the subject matter of this study; however, this paper seeks to add to the discussion the way professionals of the specialized services for STI/HIV/AIDS regard PEP availability in emergency rooms and urgent care centers in Porto Alegre. The interviewees noticed that, outside the services, PEP was understood neither as a medical emergency nor as an urgency. They did not distinguish emergency from urgency, but they remarked that in situations of consensual sexual activity PEP was not seen as a problem that needed immediate medical attention. In some medical consultations at the ambulatory care center, situations were observed in which people had come from emergency rooms and urgent care centers where they had tried to get PEP unsuccessfully. Additionally, situations involving exposure to HIV due to sexual violence, according to the interviewees' perception, were treated differently by the same emergency rooms and urgent care centers. On this matter:

> *So, emergencies also started. There, emergencies started like this: if it is a case of violence, we need to take care of it; if it is not* [a case of violence]*, let him go, he can come another day. It was exactly like this: if it was statutory rape, or it was this case or another, we take care of it; if not, then "you will have to come another day because is it not an emergency." It used to be like this: "oh, you did it, now you manage this by yourself"* (Interview, August 2015)

It is not just among health care professionals from other healthcare services that PEP was considered this way. Non-urgent perception was also shared by some interviewees who found it difficult to provide services in cases of highest-risk sexual exposure to HIV in emergency rooms and urgent care centers:

> *So, sometimes, I think it is just wrong to provide PEP at the emergency room... I have already worked there: you are with a guy who suffered a heart attack, and another guy who has paralysis, you don't know if the guy is going to be in a coma or not, and someone decided to have sex and not to use condoms and is now here seeking care in the middle of the emergency room?! It is complicated, isn't it? That means you have to stop what you're doing when you have to be with another* [patient suffering from a heart attack, etc]*. At the emergency room of the SUS, professionals are always needed, so you are always multitasking. And... things get to you, so I... I think it's wrong because you end up doing anything to get rid of that patient* [patient seeking PEP]. (Interview, August 2015)

The excerpt above reveals that the potential exposure to HIV, which is the result of a consensual sexual activity, is regarded as an event that would not require immediate medical attention, compared to other cases involving serious health conditions. Moreover, the perception of the lack of human resources in the services offered at emergency rooms and urgent care centers directly affects the notion that consensual sexual exposures to HIV do not require immediate medical attention.

Added to the perception of non-urgent medical care is the idea of blaming the user. Health care professionals noticed that, in the services offered at emergency rooms and urgent care centers, not using condoms or any type of method to prevent HIV infection was considered a voluntary act of the user who *chose to be irresponsible*. In the case of sexual violence, due to the fact that there

is physically coerced contact, victims are not to blame; they are given priority to medical care. The possibility of avoiding HIV transmission after sexual activities – consensual or not – was admitted by professionals. However, there did not seem to be an agreement among the interviewees regarding priority to medical care in the emergency rooms and urgent care centers for situations of consensual sexual exposure when those patients come in and there are patients with other health conditions to be cared for, a situation that differs from what is proposed in the protocol for PEP.

The challenges of implementing PEP

The actions taken by health care professionals make it possible to validate the gaps in the design and development of health care strategies. In this section, the challenges mentioned by health care professionals for the implementation of PEP are identified. A greater divergence was observed in the conceptions between professionals from the ambulatory care center and the counseling and testing center, which differs from the perceptions and knowledge that the health services managers and the rest of the interviewees have regarding prophylaxis.

The need to improve the organizational coordination between the ambulatory care center and the counseling and testing center in medical care for cases of consensual sexual exposure was confirmed. Concentrating PEP at the ambulatory care center complicates the fulfillment of specific actions of psychosocial care, which were mainly offered at the counseling and testing center. Beyond the fact that counseling actions were carried out at the ambulatory care services, according to an interviewee, there was a need for greater medical care to such actions:

> *No, I think that, about challenges like these, we should have a lot to improve. I think there should be a professional who is available to provide medical care for these types of situations, to give advice, to have more time to provide good counseling.* (Interview, August 2015)

In the interview above, the need for a professional counselor exclusively available for PEP is also verified. The perception of this interviewee may be regarded as a result of the concentration of activities related to PEP in few professionals. In that way, rather than the staff dominating counseling activities, as an important task at providing PEP, it is considered as a responsibility that falls on a few professionals.

According to an interviewee, in view of a possible increase in demand for PEP, the need to develop actions in public administration at the different levels (local, state, and federal) oriented to the planning of activities related to antiretroviral prevention was confirmed:

> *So, I think health services managers should already be present, observing the increased demand and foreseeing the training of the network to absorb this demand, preparation, training, planning, this has to do with management. Because it is not a crazy thing, a thing related to the services, that is something that comes from the Ministry* [of Health], *a national thing and that has... that has been planned. I think it is not that way yet, at least I haven't heard of anything like "well, let's prepare primary health care." I think that this is just a start.* (Interview, August 2015)

The challenge, in this case, is the expansion of the PEP availability in the state-run health sector. According to another interviewee, the availability was limited to a few services, a gap that forced the user to move across the city to get PEP:

> *I think there should be more places available* [for providing PEP] *because sometimes it is difficult. People who live downtown, there in the northern region, have to travel to get here, don't they? Sometimes, those people who cross the city... people who seek PEP and are able to come, visit the specialized services but, sometimes, in after-hours situations, because* [ambulatory care center] *is open from 8 a.m. to 5 p.m., and people are working. They will leave work and say: "should I go there and get a rapid test?" People will not want to expose*

> *themselves, will they?* (Interview, August 2015)

The difficulty in access to PEP is observed in specialized services, due to the working hours of these services. On this point, it should be remarked that, regardless of the PEP availability in the emergency rooms and urgent care centers which are open 24 hours, in the perception of the interviewees these services are not easy to access in cases of consensual sexual exposure. When the interviewee stated that people would not take PEP in business hours due to the possibility of social exposure, it is observed that the stigma, generally, remains as a barrier to the access of the strategy. This statement is added to the rest of negative perceptions about people who seek antiretroviral prevention.

It was also observed the issue of disseminating information about PEP:

> *People are not using prevention. So, we try to do other things, through public agencies... Of course there is a continuing dissemination effort, but if we only do this, "oh, medication is used only if this happens." But what about the prevention to avoid having to use the medication? How are they preventing people from getting infected? Are they promoting the use of condoms? They don't need to get to that point* [...] *Let this be spread more widely, or try hard to go out at night more, or what people... the way it used to be, damage control, right? Something must be done, because this is too much!* (Interview, August 2015)

The perception of the need for disseminating PEP is recurrent and paradoxical: while interviewees discussed the need for a greater dissemination of the strategy in different areas, they expressed their fear of a possible trivialization of unprotected sex, promoted by new technologies. So, the emphasis was on the dissemination of prevention strategies in general, starting from, for instance, the strategy of harm reduction and, especially, the distribution of condoms and lubricant gel. Going back to the issue related to leaving traditional prevention methods behind on the part of the population[16] was a phenomenon that had not been incorporated in the professionals' reflections. Nor had they considered it as a phenomenon that may be independent from the innovations offered by combination HIV prevention.

New dilemmas on prevention policies

Prevention based on antiretroviral medications, mainly represented by PEP and PrEP technologies, has transformed public policies on HIV prevention.[2] Such transformations are manifested in specific inconsistencies about the way they are being implemented in the state-run health sector.

Starting in the early 1990s, the services under study are made up of professionals who take part in the process of incorporating different strategies in the field of prevention, which range from biomedical to behavioral and structural interventions. For some interviewees, the current setting is focusing too much on interventions based on the use of antiretroviral medications, especially PEP and PrEP. Furthermore, although they acknowledge the relevance of these methods, these interviewees highlight the decrease in strategies with behavioral and socio-structural approaches.

The interviewees' concern about socio-structural matters that complicate HIV prevention was confirmed. Research shows that coping with HIV requires the interrelation of (biomedical, behavioral and socio-structural) strategies that are related to the subjects' realities.[3,4] In addition to the issues identified above, the perception of a drastic change in the structure of services should be added, along with a reduction in human resources, the closing of testing centers, the worsening of social issues such as urban violence and socioeconomic inequalities, which, directly or indirectly, influence the work processes on a daily basis of the health services.

The perceptions on PEP described in this study are related to the technical-normative knowledge, subjectivities and, also, a larger context that covers the implementation of actions taken by health care professionals. While antiretroviral prevention becomes real, under funding of public health and the lack of organization of traditional strategies, as well as the local context, among other factors, give rise to mistrust and uncertainty among workers. Thus, not only do

perceptions show the interviewees' points of view but also a series of interrelated events that influence health care services at the local level.

Another aspect that should be remarked is the notion above of the repeat offender, an individual analysis of professionals based on a negative connotation about subjects and their practices and the way they take over PEP. This reveals the importance of providing guidelines to promote equity, non-discrimination and respect for the vulnerabilities within services.[34] Under this perception, safe sex provided by PEP is denied and regarded as an *irresponsibility* or *negligence*. In this regard, the PEP strategy, from the point of view of professionals, becomes an element that reveals the lack of self-care, for which a repeat offender deserves a reprimand, since professionals do not regard the strategy as a *prevention method*.

Repeat offense, a legal concept formulated for someone who repeatedly commits a crime, is suitable to express an idea of deviance or crime in consensual sexual exposure to HIV. In that way, an amount of prescriptive morality is imposed to the subject's own sexual practices. In this sense, expectations related to subjectivation, responsibilization and control of themselves have been affected by new technologies of power.[35] The non-use of traditional methods goes against the principle that condoms, either male or female, are the "best" way to prevent HIV. This idea still prevails in prevention campaigns and in many biomedical discourses. In this case, perhaps the "best" prevention method is not defined by the most adjustable to the context of each person or to the method that they consider to be the best for them, in that particular moment of their lives.

The HIV/AIDS epidemic is an epidemic of meanings,[21] in which the language used is not neutral, and shows interests and power relations. In the health sector, the production of meanings about subjects and their practices is not necessarily a reflection of the objective reality. The negative idea of repeat offense about the subjects' sexual behavior may be attributed to the stigma of AIDS and sexual practices considered deviant; a stigma regarded in this study as a phenomenon that affects subjects who, in view of their difference, are negatively judged by society.[36] A subject who looks for the service to have access to PEP may be interpreted as someone with sexual practices that are "promiscuous" (with many partners) or "immoral" (related to sex work or non-traditional sexual and affective relations). Therefore, the repeat offense makes this person a stigmatized one.

As stated before, it is possible to regard the same repeat offender from a different perspective: the one of the *worried subject*, a subject who may be considered as someone who invested time and resources seeking to be aware of the PEP strategy and who is then seeking to gain access to prevention through public health policies. In this case, repeat offender may have a positive connotation: it would be a practice that indicates a concern about the subject's own sexual health, of someone who acquired the necessary knowledge to be independent of the use of the strategy and who, even if he or she finds barriers to access, seeks to get into the state-run health sector. Combination HIV prevention precisely requires an independent subject who may decide even about the use of PEP in different and repeated times. It is important to highlight that this alternative interpretation of the repeat offender, with a positive connotation, was not confirmed in the research.

A repeat offender may even be considered as an opportunity for the services to reach users with high risk of HIV infection and create a bond with them. Such users of PEP strategy, either *repeat offenders* or not, when arriving to the ambulatory care center, have access to rapid tests (HIV, syphilis and hepatitis), pre-testing and post-testing counseling and, occasionally, they have other health requests made available for them, such as hepatitis and HPV vaccines. In this case, users may be received with the idea that they came to the right place, and they may return every time they need it in order to be provided with medical care as many times as they want or need. In the ethnographic observations, however, it was observed that at the reception area there is a tone of reprimand, meaning "don't let it happen again."

PEP and PrEP strategies have been prioritized by the Ministry of Health for population groups known as *key populations* or *priority populations*: men who have sex with other men, homosexuals, sex workers, transvestites and transsexuals. It is a public administration perspective aimed to prioritize these new HIV prevention technologies for groups with greater vulnerability of infection.

Therefore, the combination HIV prevention protocol incorporates, somehow, the idea of vulnerability. However, the protocol is just one of the elements in the public administration, since if it had not been accompanied with other strategies oriented to promoting human rights – especially sexual rights and the right to non-discrimination – the protocol itself is ineffective in expanding access to new HIV prevention technologies.[37,38,39]

Reoffense, just as well as blame, creates a subject in the discourse and in the representation of professionals that takes part in the implementation of PEP in the service under observation. Performative acts, based on Butler's conception,[37] are also acts of speech that do not only describe but also constitute subjects within discursive fields of power and knowledge. It is observed that sexuality, in situations of exposure in consensual sexual activities, is performed by producing meanings in practices and in the subjects' bodies. Repeat offenders are facing the social stigmas of class, gender, sexual orientation, and race: they are irresponsible, poor, homosexual, promiscuous and non-white health service users. The stigmas that place these people as subjects who take precedence over the PEP protocol are the same that work as barriers to PEP access. Such practices place these subjects as illegitimate for the use of PEP.

FINAL CONSIDERATIONS

This research study sought to identify challenges in the implementation of PEP, based on the practices and actions taken by health care professionals, in state-run specialized services for STI/HIV/AIDS in Porto Alegre, Rio Grande do Sul, Brazil. Among the main results, an influence of contextual, organizational, and subjective elements was observed, which comprises and performs PEP implementation efforts, by defying the effectiveness of the strategy when taking into account subjects' vulnerabilities and human rights.

Implementing a public policy is not a neutral process, precisely because it is conducted by professionals who have their own points of view, interpret protocols, and come to agreements on the strategy at the local level of services. In this sense, health care professionals, who are principally responsible for transferring the public policies to the SUS beneficiaries, are facing a paradox: while the use of antiretroviral medications in HIV prevention – specially PEP and PrEP – spread nationally and internationally as a potential mechanism to deal with the HIV/AIDS epidemic, its materialization in the local reality, through the analyzed perspectives, finds flaws and potential barriers to access this strategy.

The idea of repeat offenders in PEP as a negative pre-conception about occasional practices may be manifested as discrimination in the reception area or while providing medical care; it may even get worse with specific social groups, by stigmas of class, race or color, gender expression, sexuality, disabilities, among others. Consequently, it should be suggested to focus greater attention on the process of implementing prevention methods based on the use of antiretroviral medications in the Brazilian setting. This affects the increase in actions oriented to provide training and continued education to professionals, related to both technical-normative aspects of protocols and the promotion of equity, non-discrimination, and respect towards the subjects' human rights in the health sector.

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