

## POLICIES DIRECTED TOWARDS STD/AIDS AND THEIR POLITICAL-CARE INTEGRATION IN THE CONTEXT OF THE SUS: A STUDY OF THE CITY OF FLORIANÓPOLIS, SC, BRAZIL

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**ABSTRACT:** This qualitative study, with a socio-historical perspective, aimed to examine how the process of decentralization of STD/AIDS actions took place in Florianópolis, SC, Brazil, and its effects on the level of care and administration. The data collection was based on documentary and oral sources. A total of 11 health professionals were interviewed, who performed care and/or management activities linked to STD/AIDS, during the study period (2006-2010). The results were analyzed using content analysis, resulting in two categories: The administrative decentralization of the Municipal STD/AIDS Program; The decentralization of STD/AIDS care. The restructuring of the STD/AIDS Program was part of the reorganization process of the municipal health system and the progressive incorporation of the concept of Health Surveillance. Decentralization of the actions was perceived as a condition necessary for the integration of STD/AIDS policies into the macropolitics of the SUS, however, continuous monitoring of the directions of the epidemic from the new conformation of this care policy is required.

**DESCRIPTORS:** Decentralization. Unified Health System. Health policy.

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## POLÍTICAS VOLTADAS ÀS DSTs/AIDS E SUA INTEGRAÇÃO POLÍTICO-ASSISTENCIAL NO CONTEXTO DO SUS: UM ESTUDO SOBRE O MUNICÍPIO DE FLORIANÓPOLIS-SC

**RESUMO:** Estudo qualitativo com perspectiva sóciohistórica, que objetivou analisar como o processo de descentralização das ações em DST/aids se deu no município de Florianópolis-SC, e suas repercussões no nível assistencial e administrativo. Para coleta de dados foram utilizadas fontes documentais e orais. Foram entrevistados 11 profissionais de saúde que exerceram atividades de assistência e/ou gestão vinculadas às DSTs/aids, no período do estudo (2006-2010). Os resultados foram analisados segundo análise de conteúdo, chegando a duas categorias: A descentralização administrativa do Programa Municipal DST/aids; A descentralização da assistência em DST/aids. A reestruturação do Programa DST/aids fez parte do processo de reordenação do sistema de saúde do município e incorporação do conceito ampliado de Vigilância em Saúde. A descentralização das ações foi percebida como condição necessária para a integração das políticas em DST/aids à macropolítica do SUS, porém requer um monitoramento contínuo sobre os direcionamentos da epidemia a partir da nova conformação desta política assistencial.

**DESCRIPTORIOS:** Descentralização. Sistema Único de Saúde. Política de saúde.

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## POLÍTICAS DE LA POLÍTICA DE ASISTENCIA DE ETS/SIDA Y LA INTEGRACIÓN EN EL CONTEXTO DEL SUS: UN ESTUDIO EN LA CIUDAD DE FLORIANÓPOLIS, SC, BRASIL

**RESUMEN:** Estudio cualitativo de perspectiva socio-histórica, con el fin de examinar cómo el proceso de descentralización de las ETS/SIDA tuvo lugar en Florianópolis-SC, Brazil, y sus efectos sobre la salud y administrativos. Para recopilar los datos basados en fuentes documentales y orales. Entrevistamos a 11 profesionales de la salud que ejercen actividades de asistencia y/o gestión vinculada ETS/SIDA durante el período de estudio (2006-2010). Los resultados se analizaron mediante análisis de contenido, llegando a dos categorías: Programa de descentralización administrativa municipal de ETS/SIDA, la descentralización de asistencia de ETS/SIDA. La reestructuración del Programa Nacional de ETS/SIDA fue parte del proceso de reorganización del sistema de salud municipal y la incorporación progresiva del concepto de Vigilancia de la Descentralización de la Salud de las acciones que se percibía como una condición necesaria para la integración de las políticas de ETS/SIDA en la macropolítica SUS, pero requiere un control continuo sobre las indicaciones de la epidemia de la nueva conformación de la política de asistencia.

**DESCRIPTORIOS:** Descentralización. Sistema Único de Salud. Política de salud.

## INTRODUCTION

The public health policies directed towards AIDS in Brazil have undergone transformations over the years, influenced by both the evolution of the Brazilian National Health System (SUS), as well as the evolution of the disease. In relation to the healthcare system, the institutionalization of the actions directed towards AIDS occurred in a coevolutionary way with the field of emergence of the SUS, having World Bank resources as the differential aspect, enabling progress in the implementation of prevention, diagnosis and treatment actions. In this context, one of the current concerns is the proximity of this sectorial policy with the macropolitics of the SUS, to integrate these policies and integralize the healthcare.<sup>1-2</sup>

In relation to the disease itself, in over thirty years of the epidemic, science has greatly advanced in relation to the prevention, diagnosis and treatment of the disease, causing AIDS, previously a lethal disease, to be currently considered an evolutional, chronic and potentially controllable disease.<sup>3</sup> These new directions of the epidemic and health policies have direct repercussions on the care, seeking the perspective of decentralization of the actions directed towards AIDS to other healthcare services of the SUS, including the care for asymptomatic carriers of the Human Immunodeficiency Virus (HIV) in the Primary Healthcare, with a view to consolidating the principles of universality, integrality and decentralization advocated by the SUS policy.<sup>4</sup>

The decentralization of the actions in the field of AIDS was already expressed by the National STD/AIDS Program in the 1990s, as a way to maintain the sustainability of the actions and control the epidemic. However, it can be said that the policy directed towards AIDS has evolved in segregation from the other healthcare areas. This situation is expressed in the fragmentation of the organization of healthcare actions and services, representing a challenge for the consolidation of the guiding principles of the SUS. This challenge, crucial for health in the country, needs to be addressed by managers, healthcare professionals, as well as by the users of the healthcare services and the community in general.<sup>5</sup>

Although specialized STD/HIV/AIDS services in Brazil are guided by national guidelines, in practice these services have very diverse organizational arrangements, seeking to meet the different needs of each situation.<sup>6</sup> In this study, we present the case of the municipality of Flori-

anópolis, the capital of Santa Catarina, located in southern Brazil, which reported the first case of AIDS in 1986, officially creating the Municipal STD/AIDS Program structure from 1993. This program was initially configured as an administrative unit based in the Municipal Health Secretariat and in care clinics located within the municipal care network, such as the Municipal STD/AIDS Outpatient Clinic and the Testing and Counseling Center (TCC). From the progressive consolidation of the Brazilian National Health System, the implementation of a new care approach in the municipality was sought, based on the concept of Health Surveillance, aiming to gather all the surveillance, prevention and diseases control actions into the same structure, visualizing the expansion of the surveillance object.<sup>7</sup>

From the reorganization of the services in the municipal health service of Florianópolis, the Municipal STD/AIDS Program was integrated with the Chronic Diseases Technical Department of the Epidemiological Surveillance of the municipality and the care to patients with HIV/AIDS referred to the specialized care services in the polyclinics of reference in the city. The changes generated by this new political-care perspective provoked different reactions among the health professionals, involving both in the formulation process of this policy, as well as in the context of the professional practices.

Considering that organizational change can generate resistance and conflict, as well as raise issues, this study was guided by formulating the following research questions: how was the process of decentralization of STD/AIDS carried out in the municipality of Florianópolis? What repercussions in the care and organization of the services were incurred with this process?

Thus, this study aimed to analyze how the process of decentralization of STD/AIDS actions occurred in Florianópolis and its impact on the healthcare and administrative levels.

## METHOD

This is a qualitative, sociohistorical study, which used new history as the philosophical basis.<sup>8</sup> New history represents a problematic, explanatory history that seeks to not only narrate the events, but to analyze the structures.<sup>9</sup> The historical perspective values qualitative analysis and the importance of individual experiences, opening space for the study of the present, the political, and

the cultural, and is applicable to various themes of social interest, reincorporating the role of the individual in the processes studied, taking into account its openness for the use of oral sources.<sup>10</sup>

For the data collection, primary and secondary documentary, and oral sources were used. Primary documentary sources were the laws, ordinances, resolutions, Actions and Goals Plans (AGP) of the state and municipality, minutes, projects, and reports that could contribute to the elucidation of the moment studied. The secondary sources were theses, dissertations, pamphlets, books, conference proceedings, and written media material, especially those that referenced the AIDS epidemic and public policies in Florianópolis.

New history allows the use of different sources for the comprehension of the studied object, with oral statements being an important source. Accordingly, 11 subjects were interviewed, including four nurses, three physicians, two psychologists and two social workers, who performed care and/or coordination activities in the STD/AIDS Program of the municipality and had experienced these processes of transformation in the STD/AIDS Program. The interviews were conducted according to the Thematic Oral History technique.<sup>11</sup> Throughout the text, the statements of the nurses are identified using E1, E2, E3, E4, of the physicians using M1, M2 and M3, of the psychologists using P1 and P2, and of the social workers using AS1 and AS2. For the data analysis the content analysis technique was used.<sup>12</sup>

The historical moment studied begins in 2006, when the Health Surveillance Code was established in the municipality, organizing the five types of surveillance (Health, Epidemiological, Nutritional, Environmental Health, and Occupational Health Surveillance), and an administrative reorganization within Epidemiological Surveillance took place, in which the Municipal STD/AIDS Program was incorporated into the Noncommunicable Chronic Diseases Sector, being deprived of its official coordination. This year was also marked by the closure of the STD/AIDS Outpatient Clinic, resulting in new directions for STD/AIDS care in the municipality. The final point is 2010, due to the intensification of the debate related to the monitoring of HIV positive asymptomatic patients within the primary care network.

This study was approved by the Human Research Ethics Committee of the Federal University of Santa Catarina, under number 592-315996, on February 22, 2010. All ethical research principles

were observed in all the phases of the study, according to resolution 196 of the National Health Council<sup>13</sup> The results are the product of the analysis of the interviews, where the units of analysis previously selected (keywords) were classified through the grouping of similarities, establishment of sub-categories, and their regrouping for the formation of the categories. The analysis of oral histories was also supported by information obtained from the primary and secondary documents, taking the National Health Policy as the analysis reference, especially the concepts of universality, integrality and decentralization, known as the doctrinal and organizational principles of the SUS.

## RESULTS AND DISCUSSION

The results are organized in two categories: The administrative decentralization of the STD/AIDS Program in Florianópolis; and The decentralization of STD/AIDS care in Florianópolis.

### **The administrative decentralization of the STD/AIDS Program in Florianópolis**

Concerning the Municipal STD/AIDS Program in Florianópolis, the administrative team was still structured in the SMSF in 1993, consisting of a coordinator (position that in the trajectory of the program was occupied sequentially by four nurses and then by a physician) and other higher level technical professionals (nurses, psychologists), an administrative technician, a nursing technician, and interns. These professionals developed various activities, such as prevention campaigns among the general population and specific groups, training in the healthcare network of the municipality, epidemiological surveillance activities, planning of the AGP actions, technical coordination at the STD/AIDS Testing and Counseling Centre and the Outpatient Clinic, and other links with the municipal and state public healthcare network and non-governmental organizations active in the municipality.<sup>14</sup>

Before the official adherence to the Health Pact, which occurred in 2007, some processes were undertaken in the district health system in 2006, from a new management in the SMSF, such as the closure of the of Public Health Department, the ascending reorganization of Healthcare according to the Family Health Strategy, and the restructuring of the Health Surveillance, among others. As a result of these processes, the Municipal Health Plan (2007-2010) made some changes



in the administrative structure, such as the consolidation of the Health Regions into the Official Organization Chart of the SMSF, and the creation of an Epidemiological Surveillance Management, which started to coordinate all the technical areas involved, among them the Area of Communicable Chronic Diseases, which was linked to AIDS.<sup>12</sup> At this time, the coordination of the Municipal STD/AIDS Program was losing strength, until its incorporation into the new administrative arrangement:

*[...] when the new secretary came, he put a supervisor in the public health department and a supervisor in the health surveillance. There were two physicians who thought the AIDS program was too powerful and that its power had to be decreased. In this decrease of the power, they made the organization chart without the STD/AIDS coordination (E6).*

One interpretation of the dissolution of the coordination of the program is situated in the question of autonomy and visibility when compared to the other municipal programs, especially related to the financial resources received regularly through the AGP. Although these issues are part of the common sense in the SMSF environment, the issue was not limited to these aspects, but included the need to reorder the work system within the institution itself, which involved all the sectors, aiming to accompany the recent movement of the formation and consolidation of Health Surveillance in Brazil. With this, health surveillance, the prevention and control of diseases, health promotion, surveillance, communicable and non-communicable diseases, environmental health surveillance, epidemiological information, and analysis of the health situation were incorporated.<sup>15</sup>

Faced with this reorganization of the SMSF, the Municipal STD/AIDS Program was integrated into the Epidemiological Surveillance of the municipality, being adding to the Communicable Chronic Diseases Technical Department:

*[...] then since 2006 it was a program, and the coordination left. We became part of the surveillance as a whole, and in 2007 the new coordinator of surveillance took over, which turned into the chronic diseases sector, and AIDS was within the chronic diseases sector. So the people who previously worked in the chronic diseases sector and with AIDS, were now also responsible for leprosy, tuberculosis, leishmaniasis, AIDS and STDs (P1).*

*[...] so this was something that ended up as a great gain, with the integration between the programs, because the population that was at risk became the focus rather than the program (M6).*

The focus given to AIDS, due to the history of the disease, independent funding, autonomy and visibility, began to fade from the moment that there was integration into the Communicable Chronic Diseases Sector, because the perspective was restricted to the disease only, and it started to be concretely perceived that the same individual who was vulnerable to AIDS was also vulnerable to other diseases or already presented other comorbidities, such as hepatitis. This was a trend that was also achieved in the National STD/AIDS Program, which, in 2009, combined the National Viral Hepatitis Program and the STD/AIDS State Management of Santa Catarina, and added Viral Hepatitis in 2010. However, one of the consequences of the reorganization of the programs was a lack of human resources to meet this new demand:

*I think we gained a lot with respect to the comprehension of what epidemiological surveillance is and the role of epidemiological surveillance, in relation to AIDS, HIV, tuberculosis, leprosy, leishmaniasis, and hepatitis. However, I think we lost autonomy and the capacity for work. I think it was not necessarily because of this change, but it was because this change was not accompanied by an actual restructuring of surveillance in order to include more professional, to increase the team size relative to the amount of work (P2).*

*the team has decreased considerably. Because of this, some actions are no longer performed, and it was the flagship of the Program. At the same time, I think it made us think about the possibility of retransforming it, including the prevention work in the Primary Units, which are much more able to reach the community than the people there in the program (P1).*

From this new conformation of the service, the professionals recognized that they combined knowledge in relation to Epidemiological Surveillance, but perceived the need for a restructuring of the sector itself, in order to realign the volume of work and number of personal. The education and prevention actions, perceived as pillars of the Municipal STD/AIDS Program, were negatively affected faced with all the combined work and the difficulty in defining the priorities of the service. Throughout the period of practice of the STD/AIDS Program in the municipality, various activities were conducted in schools, such as the School Health Project, in companies, such as the STD/AIDS Prevention Project, with the elderly and other population segments, as well as several specific campaigns aimed at the general population.<sup>14</sup>

However, it also considered that this new condition is shown as a possibility for the assumption of prevention activities in the Primary Healthcare, due to the Family Health Teams being part of the community. This perception therefore created better conditions to reach the population to carry out primary prevention, since this constitutes a network of branched services, in which their teams work with a focus on health promotion, being included in the community.<sup>16</sup> Although some professionals felt insecure about the new configuration of the municipal health policy, others saw this change as something very positive:

*[...] so this was something that ended up being a great gain with the integration between programs, especially what has been done within the surveillance. Apart from the surveillance, the desired speed has still not been achieved, the AIDS personnel are no longer the AIDS personnel, now they are the surveillance personnel as well as the tuberculosis personnel, the hepatitis personnel, the immunization personnel, because the focus shifted to the population that was at risk and away from the Program (M6).*

Regarding the formation of specific health programs, even in the 1980s attention was already being given to the public health strategies of Latin American countries aimed at the development of vertical or specific care models for each illness. Although these strategies are recognized as positive, as already stated, they did little to contribute to the development of permanent healthcare services for the population in general.<sup>17</sup> In this sense, we can see that the debate around the issue is not new, and that the main concern was in the deconstruction of the great fragmentation of health constructed over the years, requiring the adoption of a new political-care perspective guided by the integration of actions.

Even considering the importance of specialization and of the distinct areas of technical knowledge of the teams, it is unacceptable that they continue working in isolation, each focused on their area of expertise. Technical groups that control mosquitoes, water and food quality, tuberculosis, meningitis, AIDS, measles, leprosy, among other diseases and health problems, should seek articulation and planning, taking into account that the reality is indivisible and interrelated.<sup>18</sup> Thus, integrality is presented as a concrete possibility for relating the organization of the work in the services and in the healthcare practices, seeking to overcome the existing reductionism in our system.<sup>19</sup>

## The decentralization of STD/AIDS care in Florianópolis

Following the restructuring of the SMSF, started in 2006, the interventions carried out at the administrative level of the Program were accompanied by simultaneous transformations in the care, specifically in the dynamic of the STD/AIDS Outpatient Clinic, when it left its initial headquarters due to the reform of the Health Centre, which was transformed into a Municipal Polyclinic:

*[...] different AIDS care was thought about. Therefore the STD/AIDS outpatient clinic no longer exists here, it is a past chapter. So how is it structured here? As a polyclinic with specialized care. Within the specialties that the polyclinic deals with, it tackles infectious diseases. What does infectology deal with? The patients with HIV, with AIDS, and patients with hepatitis C, co-infected, HIV with Hepatitis C. The STDs are for the health clinics to treat (E4).*

On August 13, 2007 the Municipal Polyclinic was inaugurated, progressively consolidating the supply of intermediate complexity services by the municipal management, backed by both the Agreed and Integrated Programming (PPI), as well as by its own adherence to the Health Pact, initiating various care specialties. With this opportunity, STDs were definitively decentralized to the Health Centers, and the infectious disease care, which was restricted to the patients with HIV/AIDS of the STD/AIDS Outpatient Clinic, now started to be considered an infectology specialty. This specialty was initially decentralized into two points of the city, also covering other infectious diseases.<sup>14</sup>

Through this new conformation of the service, the care team of the outpatient clinic, structured by some members since the early 1990s, was divided to comply with the principle of decentralization, generating a loss of identity and insecurity faced with the unknown, breaking the bond between the team members and the patients, who would now be assisted by other professionals, considering that some of these professionals did not remain in these services. This fact generated resistance and fears regarding change in the care:

*[...] in relation to the outpatient clinic, which was the existing reference service at the time, it was very complicated, because there was this thing of the loss of identity, of the fear of the loss of identity within the network. ' - Ah, but I know how to attend AIDS patients and I will also have to see hepatitis patients, will I have to see tuberculosis patients too? It was a little more difficult this change, especially with the involvement*

of the NGOs that had this fear: 'they are destroying the reference outpatient clinic'. The idea was not that they were creating a more comprehensive outpatient clinic nor expanding the service, because in place of one there would be two reference places. The idea was: 'the way that we know will no longer exist'. And change always creates fear (M6).

The change in patient care with HIV/AIDS was conceived in different ways among the professionals involved with the program, positioning themselves in distinct positions: those who positioned themselves against this form of decentralization, those who were in favor of it, and even those who did not enter directly into the merits of the issue, however, presented important considerations regarding the organizational form of the care. Although this new configuration of the care caused disruptions in the conformation of the service, with repercussions for both the professionals and the patients, some professionals perceived the need to go through this process in order to structure a municipal policy for assisting the patient with HIV/AIDS, which is illustrated by the following statement:

*[...] the fact that we have more reference services, I think this had to be. It is clear that the change was somewhat traumatic, it had always been concentrated here in the center, so the patients were all very familiar with the scheme they had there. On the other hand, I think that we, as a municipality, cannot organize ourselves through personal particularities of one professional or another, or how a service is historically organized. So I think we have to have a municipal policy, and in this sense, this change was important (P2).*

Among the professionals involved in the care of these patients, it was thought that the healthcare system was not ready to receive this patient in a decentralized manner. They believed a unique service to meet this demand was still needed in order to ensure effective outpatient follow-up and avoid problems related to the abandonment of treatment and resistance to therapeutics, which would compromise the best treatment and quality of life of people living with HIV/AIDS:

*[...] unfortunately there are two forms of the disease epidemic in Brazil. There are the people that get treated, taking the medication and living well, and there is a large group of people who do not have access to the medication, for various reasons, but they are not treated, so they die. So AIDS is still killing the same as it was killing in the 80s. Because these people have no access to these drugs, which are great. They arrive late, very sick, the condition is complicated, they do*

*not have monitoring and they end up dying, that's sad [...]. Early diagnosis would be a very important thing to define. People today are living with HIV for 20, 25 years and living well, but only those who receive an early diagnosis, who receive complete health monitoring, they will live for decades (M2).*

Despite the technological resources available, AIDS continues claiming lives, especially among those who were diagnosed later, often due to difficult access to healthcare services. Statistical data and studies related to AIDS mortality highlight the need to observe the quality of care and how it is conducted in the services.<sup>20</sup> In addition to universal access and the provision of antiretroviral drugs, the quality of care refers to the care process in its totality and complexity, articulating the principles of integrality to those of universality.<sup>21</sup>

The care for HIV/AIDS patients relies on specific technological proposals, such as mechanisms established to trace cases, pre- and post-test counseling, the reception of patients, and the performance of adherence groups, conducted by multidisciplinary teams trained for this purpose. This healthcare proposal tends to conflict with the prevailing technological pattern in specialty outpatient clinics, where the care is organized around the individual clinical approach. The fragmentation of individuals into specialties perpetuates outdated health practice models, compromising the principles of integrality and resulting in the fragmentation of care. This fragmented care becomes insufficient to meet the complexity of living with AIDS, considering its stigmatizing, communicable and, until now, incurable condition, and its various psychosocial effects.<sup>6,22</sup>

Currently, new care proposals are emerging, such as the monitoring of people living with HIV by the Family Health Team, since HIV infection is currently designed as a chronic, evolutionary and potentially controllable disease.<sup>23</sup> This care proposal was already visualized in the Municipal Health Plan of Florianópolis, in 2007, presented as "the guideline for the municipal STD/AIDS program to gradually transfer the monitoring of HIV cases to Health Centers, allowing better access for patients to the healthcare services".<sup>15:57</sup> This proposal has been gradually implemented in some health units, although it has not yet been fully put into practice:

*[...] there is a movement, which is to decentralize HIV care, to keep the polyclinics really as the references, but the people, the HIV patients without complications would be treated in the health center, in the entire*



network, and then only the most complicated cases or those that need a different type of care would go to the references. So there is this great change that should be happening, however, it is not very structured yet (P2).

In 2010, this discussion was initiated together with the primary healthcare, in the form of training, aiming to qualified the professionals of the Family Health Strategy for accommodating this demand. However, this approach generated different reactions among the professionals, because:

[...] *in the training, some professionals felt insecure. It was discussed that the Family Health Team must take ownership of this knowledge, to know that they can manage, that they don't have to be scared, it is the same as treating patients tuberculosis, with hypertension, diabetes [...]. So, many people want to take ownership of the knowledge and understand that the patient is theirs, others were a bit more concerned and some said that even if everything is fine, they should be sent to infectology. Then some professionals agreed, but the health network changes a lot, some professionals already left, and this makes it difficult (E7).*

One of the difficulties in adopting this type of procedure is the high turnover of the FHS professionals, which prevents the continuity of this care logic and the formation of the bond with the patient. Even with regard to STD/AIDS prevention actions in the primary care services, the challenge of overcoming the fragmentation still remains in this level of care, aiming for integrality in the healthcare practices. In addition to the lack of basic structural aspects, such as a sufficient quantity of professionals and adequate physical spaces, technical preparation for approaches of this nature are also lacking in these services.<sup>24</sup>

Another issue to consider is that, even among professionals of the Family Health Strategy, there is no practical consensus of what belongs to their area or does not. This is even envisioned in issues that should theoretically already be overcome, such as the practice of counseling and the request for HIV testing, which is sometimes still referred to the TCC, as can be seen in the following statement:

[...] *they talk of decentralization, which is also a proposal of the SUS. Only I see that this decentralization, it does not happen, because who are most of these people referred to us [TCC]? They come to us because they went through the health units, or because the professionals who were trained have left, or they are there but do not want to give counseling so they refer them to us (AS1).*

Questions that have been debated in the municipality for many years, such as training in

the healthcare network for the decentralization of HIV testing into the health units since the beginning of the STD/AIDS Program, have not yet been fully incorporated, either due to resistance, unprepared professionals, or the high turnover that is characteristic in this context, leading to unnecessary referrals in the current context of the healthcare system.

In agreement with one study<sup>25</sup> that addressed the perspective of healthcare professionals regarding the care of people living with HIV/AIDS, the specific preparation to treat these users would still be restricted to the professionals of the specialized centers, resulting in a discontinuity of care for the HIV positive people when they are treated in other SUS services. The study draws attention to aspects of the professional formation in the health area, leading to a reflection regarding the competences expected of the healthcare professionals in the care of people with HIV/AIDS. In this context, the nurse, being a professional member of the multidisciplinary team in diverse areas, has much to contribute, being in the teams of the specialized STD/AIDS services, as well as in the Family Health Teams, developing interventions that promote the health and quality of lives of the people living with HIV/AIDS, and enabling the subjects to enhance their self-care ability.<sup>23,26</sup>

## FINAL CONSIDERATIONS

The restructuring of the STD/AIDS Program has integrated the process of reorganization of the municipal healthcare system in Florianópolis, initiated with the establishment of the expanded concept of Health Surveillance. We can consider that, from the political-care reality presented, the administrative reorganization of the Municipal STD/AIDS Program generated a change of perspective in which the focus is no longer the disease itself, giving greater visibility to the population exposed to different situations of vulnerability. One of the concerns highlighted, however, was the structuring of the team to meet the new demands generated by the new conformations of the service.

Regarding the care, several points of tension could be noticed, taking into account the concern of the care professionals with the issue of access to early diagnosis and treatment, ensuring effective outpatient monitoring, and the formation/breaking of bonds, faced with the high turnover of professionals in Primary Health Care. According to the literature, it is expected that the monitoring of people with HIV in Primary Health Care is

performed under some conditions, with trained care teams, maintenance of the professionals in the teams, willingness and commitment of the professionals, and the support of an interdisciplinary team that is able to cope with the care demands of these patients. Integrality, as the keystone of the healthcare practices, requires not only organizational and political issues, but a philosophy of care that can encompass the specificities of the user.

The description of the process of decentralization of STD/AIDS actions in Florianópolis, may contribute to establishing a point of comparison with other local realities and, if possible, to correcting and improving the consolidation of the Brazilian National Health System. In this sense, we observed the need for a more precise evaluation of the consequences of this municipal policy, through epidemiological monitoring and programmatic monitoring of the prevention, care and promotion of health actions directed towards STD/AIDS, including public participation in the enforcement of the rights of the citizen.

In this context, the nurse, as a professional involved in the planning and implementation of the healthcare policies in diverse services, should be aware of the directions of these policies, in order to contribute to the control of this epidemic, as well as for the development of the Brazilian National Health System in all its principles.

## REFERENCES

1. Couto MH. Brasil: a estratégia brasileira de enfrentamento à epidemia de HIV/AIDS e sua integração com o Sistema Único de Saúde [online]. 2009 [acesso 2011 Out]; 02 Disponível em: [portales.saude.sc.gov.br/index.php?option=com\\_docman&task](http://portales.saude.sc.gov.br/index.php?option=com_docman&task)
2. Campos CEA. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. *Ciênc Saúde Coletiva*. 2003 Abr; 8(2):569-84.
3. Nemes MIB, Souza MFM, Kalichman AO, Granjeiro A, Souza RA, Lopes JF. Prevalência da aderência e fatores associados. In: Noletto D (editor). *Aderência ao tratamento por anti-retrovirais em serviços públicos no Estado de São Paulo*. Brasília (DF): Ministério da Saúde/Secretaria de Políticas de Saúde/Coordenação Nacional de DST e Aids; 2000.
4. Brasil. Constituição da República Federativa do Brasil: artigo 196. Senado Federal, 05 Out 1988 [acesso 2009 set 14]. Disponível em: [http://www.senado.gov.br/legislacao/const/con1988/CON1988\\_05.10.1988/art\\_196\\_shtm](http://www.senado.gov.br/legislacao/const/con1988/CON1988_05.10.1988/art_196_shtm)
5. Cherchiglia ML, Acurcio FA, Melo APS. O desafio de construir a integralidade das ações de saúde mental e IST/AIDS no Sistema Único de Saúde. In: Ministério da Saúde (BR). Secretaria de Vigilância à Saúde. Programa Nacional de DST e aids. *Prevenção e atenção às IST/aids na saúde mental no Brasil: análises, desafios e perspectivas Projeto PESSOAS*. Brasília (DF): ASCOM, 2008. p.19-29.
6. Borges MJK, Sampaio AS, Gurgel IGD. Trabalho em equipe e interdisciplinaridade: desafios para a efetivação da integralidade na assistência ambulatorial às pessoas vivendo com HIV/aids em Pernambuco. *Ciênc Saúde Coletiva*. 2012 Jan; 17(1):147-56.
7. Brasil. Conselho Nacional de Secretários de Saúde. *Vigilância em Saúde - Parte 1 / Conselho Nacional de Secretários de Saúde*. Brasília (DF): CONASS; 2011.
8. Le Goff, J. *A história nova*. São Paulo (SP): Martins Fontes; 2005.
9. Padilha MICS, Borenstein MS. O método de pesquisa histórica na enfermagem. *Texto Contexto Enferm*. 2005 Out-Dez; 14(4):575-84.
10. Ferreira MM. História, tempo presente e história oral. *Topoi*. 2002 Dez; 3(2):314-32.
11. Alberti V. *Manual de história oral*. 3ª ed. Rio de Janeiro (RJ): FGV; 2005.
12. Bardin L. *Análise de conteúdo*. Lisboa (PT): Edições 70; 2004.
13. Brasil. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. [Acesso 2009 fev 18]. Disponível em: [http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/Resolucao\\_196\\_de\\_10\\_10\\_1996.pdf](http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/Resolucao_196_de_10_10_1996.pdf)
14. Maliska ICA. *A implantação das políticas públicas de saúde em aids no município de Florianópolis-SC: um estudo do período de 1986 a 2010 [tese]*. Florianópolis (SC): Universidade Federal de Santa Catarina. Programa de Pós-Graduação em Enfermagem; 2012.
15. Prefeitura Municipal da Florianópolis. Secretaria Municipal de Saúde. *Plano Municipal de Saúde 2007-2010 [documento institucional]* Florianópolis (SC); 2007
16. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. *Vigilância em Saúde no SUS: fortalecendo a capacidade de resposta aos velhos e novos desafios*. Brasília (DF): MS; 2006.
17. Castellanos PL. *Epidemiología y organización de los servicios: la formación en epidemiología para el desarrollo de los servicios de salud*. Organización Panamericana de la Salud; 1990. 131 p. (OPS. Serie Desarrollo de Recursos Humanos, 88) [acesso 2013 Mar 25]. Disponível em: <http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk&exprSearch=368672&indexSearch=ID>



18. Campos CEA. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. *Ciênc Saúde Coletiva*. 2003; 8(2):569-84.
19. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Mattos RA, Pinheiro R (org.). *Os sentidos da integralidade na atenção e no cuidado à saúde*. Rio de Janeiro (RJ): IMS/UERJ-CEPESC-ABRASCO; 2006. 39-64.
20. Barboza R. *Gestão do Programa Estadual DST/aids de São Paulo: uma análise do processo de descentralização das ações no período de 1994 a 2003* [dissertação]. São Paulo (SP): Programa de Pós-Graduação em Ciências da Coordenadoria de Controle de Doenças da Secretaria de Estado da Saúde de São Paulo; 2006.
21. Reis AC, Santos EM, Cruz MM. A mortalidade por aids no Brasil: um estudo exploratório de sua evolução temporal. *Epidemiol Serv Saúde*. 2007 Jul-Set; 16(3):195-205.
22. Nemes MIB, Castanheira ERL, Melchior R, Alves MTSSB, Basso CR. Avaliação da qualidade da assistência no programa de AIDS: questões para a investigação em serviços de saúde no Brasil. *Cad Saúde Pública*. 2004; 20(2):310-21. [acesso 2011 Out 14]. Disponível em: [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2004000800024&lng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2004000800024&lng=en)
23. Reis RK, Santos CB, Dantas RAS, Gir E. Qualidade de vida, aspectos sociodemográficos e de sexualidade de pessoas vivendo com HIV/aids. *Texto Contexto Enferm*. 2011 Jul-Set; 20(3):565-75.
24. Ferraz DAS, Nemes MIB. Avaliação da implantação de atividades de prevenção das DST/AIDS na atenção básica: um estudo de caso na região Metropolitana de São Paulo, Brasil. *Cad Saúde Pública*. 2009; 25(Sup 2):240-50.
25. Sadala MLA, Marques SL. Vinte anos de assistência a pessoas vivendo com HIV/AIDS no Brasil: a perspectiva de profissionais da saúde. *Cad Saúde Pública*. 2006; 22(11):2369-78.
26. Martins SS, Martins TSS. Adesão ao tratamento antirretroviral: vivências de escolares. *Texto Contexto Enferm*. 2011 Jan-Mar; 20(1):111-8.