dx.doi.org/10.5380/ce.v26i0.74976

Cogitare enferm. 2021, v26:e74976

Cogitare Enfermagem

ORIGINAL ARTICLE

PROGRAMMATIC VULNERABILITY TO STI/AIDS IN PRIMARY HEALTH CARE: A HABITUS PERMEATED BY SYMBOLIC VIOLENCE

Inacia Sátiro Xavier de França[1]
Emerson Eduardo Farias Basílio[1]
Jamilly da Silva Aragão[1]
Isabella Medeiros de Oliveira Magalhães[1]
Amanda de Brito Rangel Pereira[1]
Alexsandro Silva Coura[1]

ABSTRACT

Objective: to identify programmatic vulnerability to Sexually Transmitted Infections/AIDS in Primary Health Care.

Method: descriptive study, conducted in 2018, in 52 Basic Health Units of a municipality in northeastern Brazil. A questionnaire was applied to the unit´s technical manager, identifying the vulnerability markers which were analyzed using descriptive statistics and in the light of Bourdieu`s sociology of Symbolic Power.

Results: the units stood out with average programmatic vulnerability to infrastructure (55.3%), prevention actions (67.8%) and treatment (60.4%). And with low vulnerability the units with regard to prenatal and postpartum actions in relation to STI/AIDS (93.2%) and the integration of actions (61.5%).

Conclusion: despite the potentiality of prenatal and postpartum markers and the integration of actions, the most frequent weaknesses indicate that Primary Health Care is still permeated by symbolic violence in STI/AIDS care.

DESCRIPTORS: Health Vulnerability; Sexually Transmitted Infections (Sexually Transmitted Diseases); Integrality in Health; Primary Health Care, Health Services.

VULNERABILIDAD PROGRAMÁTICA A LAS IST/AIDS EN LA ATENCIÓN PRIMÁRIA DE SALUD: UN HABITUS PERMEADO DE VIOLENCIA SIMBÓLICA

RESUMEN:

Objetivo: identificar la vulnerabilidad programática a las Enfermedades de Transmisión Sexual /Aids en la Atención Primaria de Salud. Método: estudio descriptivo realizado en 2018 en 52 Unidades Básicas de Salud de un municipio del Nordeste de Brasil. Se aplicó un cuestionario con el responsable técnico de la unidad, identificando los marcadores de vulnerabilidad, que fueron analizados mediante estadística descriptiva y a la luz de la sociología del Poder Simbólico de Bourdieu. Resultados: se destacaron con una media vulnerabilidad programática las unidades con relación a la infraestructura (55,3%), acciones de prevención (67,8%) y el tratamiento (60,4%). Y con baja vulnerabilidad las unidades con relación a las acciones de prenatal y puerperio en relación a las ETS/SIDA (93,2%) y a la integración de las acciones (61,5%). Conclusión: a pesar de la potencialidad de los marcadores del prenatal y puerperio y de la integración de las acciones, las fragilidades de mayor frecuencia indican que la Atención Primaria de Salud todavía está impregnada de la violencia simbólica en la asistencia a las ETS/SIDA.

DESCRIPTORES: Vulnerabilidad en Salud; Enfermedades de Transmisión Sexual; Integralidad en Salud; Atención Primaria de Salud, Servicios de Salud.

[1]Universidade Estadual da Paraíba. Campina Grande, PB, Brasil.

INTRODUCTION

Cases of Sexually Transmitted Infections (STI) increase daily worldwide, with higher prevalence in underdeveloped countries. For its reduction and/or eradication, it is important to develop preventive and control actions that involve behavioral aspects, social characteristics of individuals and health sector strategies [1-2].

Per year, it is estimated a total of 357 million infections by Chlamydia (131 million), Gonorrhea (78 million), Syphilis (5.6 million) or Trichomoniasis (143 million). Regarding HIV/AIDS, in 2017, in Brazil, there were 882,810 people infected, with an average of 40,000 new cases per year. In the world, there are about 36.7 million with AIDS [1,3-4].

In this context, the concept of vulnerability in health is understood by several individual and collective factors that lead to varying degrees of susceptibility of the individual to illness, especially to HIV, and can be explained by the dimensions: individual, social and programmatic [5]. Individual vulnerability is based on the perception of the quality and degree of information that the individual has, contributing to his exposure or defense. Social vulnerability refers to the environment in which the individual is inserted and the possibilities of facing social, cultural, economic, and health barriers, among others. The programmatic vulnerability considers how the various social services should act on the individual's quality of life, seeking to avoid exposure to health risks through promotion and protection actions [5].

From this perspective, it is understood that vulnerability may have an interlocution with Bourdieu's sociology of Symbolic Power, in which social, cultural, moral and political aspects form the *habitus* of the community in question, this construct being preponderant in the social locus in which the person is inserted. Thus, it is within the *habitus* that, according to the archetypes of collective representation, symbolic violence emerges, which consists of the constant practices that favor the hegemony of dominant groups and, consequently, social exclusion [6].

Since symbolic violence is a socially elaborated, legitimated, and reproduced structure, its transformation or modification will only happen if the clash between social classes allows it, otherwise, symbolic violence is naturalized in an unconscious way even for the harmed subjects [6].

Regarding the impact of *habitus* and symbolic violence in the care context of people living with HIV, it is worth exemplifying this phenomenon with a study conducted in the United States with the participation of African Americans, Blacks and Latin Americans living with HIV. These participants report symbolic violence triggering serious adverse consequences for physical and mental health, such as social exclusions, harm and stigma, disconnection from HIV care, and discontinuation of HIV medications [7].

In light of this example and correlating Bourdieusian sociology with the various dimensions inherent in the social field of health and nursing, it is stated that "the *habitus* becomes explicit in the relationships with the client and family and with health agents in the care actions, in the management of the team and of the services that constitute the organizational structure of the institutions"[8].

Thus, Primary Health Care (PHC), as the gateway to other services, is a vast field to study the vulnerability and symbolic violence that affect users. In PHC, the population is considered in its particularities, performing actions at individual and collective levels, with emphasis on promotion, prevention, diagnosis, treatment, rehabilitation and health maintenance, providing better living conditions [9].

It is considered that Bourdieusian sociology provides the ideal theoretical support for reflection about the work process of PHC nursing, concerning STI/AIDS prevention and

confrontation, and to what extent programmatic vulnerability to STI/AIDS is permeated by symbolic violence.

The relevance of the study stems from the insufficiency of scientific publications in the health area addressing this theme, considering the managerial and organizational approach. Furthermore, the practice of nurses is governed by "regular conducts" or by the "regularity of conducts" established by the institutions that define the norms, values and competencies that should be internalized by their agents [8].

It is estimated that the results of this study can motivate managers and health professionals to reflect on this theme and adopt strategies to minimize/resolve those situations that cause vulnerability and symbolic violence, important for the prevention and confrontation of STI/AIDS. Therefore, this study aimed to identify the programmatic vulnerability to STI/AIDS in Primary Health Care.

METHOD

This is a descriptive study, conducted from February to May 2018, in the Basic Health Units (BHU) of a municipality in northeastern Brazil.

Currently, the municipality has 77 BHU, 71 in urban and 6 in rural areas, distributed in eight health districts. All BHU in urban areas were contacted to participate in the study and a total of 52 units returned the completed questionnaire. Inclusion criteria were professionals delimited as the unit's technical manager. The BHU located in rural areas (six) were excluded.

After authorization from the local Health Secretariat, visits to the UBS were made to present the research to the person technically responsible for each unit, who was instructed to meet with the multiprofessional team to answer the questionnaire, with a deadline of one month for delivery.

For data collection, a Questionnaire validated by Val's study [10] was used. The instrument has 51 objective questions distributed in Programmatic Vulnerability Markers: 1-Infrastructure for STI/AIDS Prevention and Assistance actions (16 items); 2-Prevention actions regarding STI/AIDS (10 items); 3-Response to STI/AIDS treatment needs (seven items); 4-Pre-natal and puerperal actions regarding STI/AIDS care (11 items); 5-Integration of actions between UBS, Reference and Training Center/Specialized Care Service (CRT/SAE) on HIV/AIDS and maternity (eight items), as well as questions on identification and characterization of the BHU.

The analysis followed the model proposed by Val's study [10]. The degree of vulnerability of each BHU was evaluated by the sum of the items of each marker, obtaining a minimum and maximum score, constituting a Programmatic Vulnerability Scale in High (below 25%), Medium (from 25% to 75%) and Low (from 75% to 100%).

The items were classified with a value of one for positive answers, when "it meets a certain condition", and zero for negative answers, when "it does not meet a certain condition"[10]. After the description of the markers, the analysis was made in the light of Bourdieu's sociology of Symbolic Power [6].

The study data were processed and analyzed in software for statistical data analysis, using absolute and relative frequency measures. Regarding the items of the markers in which there was a refusal to answer, or the individual did not know how to answer, they were coded in the analysis as missing values (missing), evaluating those who answered the respective items.

Regarding the ethical aspects, the study was approved on April 9th, 2014 by the Research Ethics Committee of the Universidade Estadual da Paraíba under opinion No. 11.

RESULTS

As for the typology, the units were classified as: 26 (50%) exclusive "traditional" BHU, 20 (38.5%) exclusive Family Health Strategy (FHS) and six (11.5%) BHU with "mixed" FHS, totaling 52 units. As for the education of those responsible for the BHU, 46 (88.5%) were Nursing professionals and six (11.5%) did not specify their education.

According to Table 1, the best evaluated items at marker 1 were: daily collection of laboratory tests and active search. The items that least met the recommendations were: distribution of IUD (Intrauterine Device) and Counseling for HIV pre- and post-testing at Marker 2. Regarding the availability of basic materials for educational activities, such as cardboard or similar, brushes, string, glue, scissors, pelvic and penis models, male and female condoms, posters and/or leaflets and/or serial album on STI/HIV, 28 (52.8%) BHU reported not having these materials.

Table 1 - Distribution of Basic Health Units according to markers 1 and 2. Campina Grande, PB, Brazil, 2018 (continues)

Infrastructure for the realization of prevention and assistance actions on STI/AIDS	Does not meet n (%)	Meets n (%)
Office with privacy	5(9,8)	46(90,2)
Room for educational activity	17(32,7)	35(67,3)
Availability of basic materials for educational activity	28(53,8)	24(46,2)
Distribution of contraceptive and preventive supplies:		
Pill	11(22)	39(78)
Injectable	13(26,5)	36(73,5)
IUD	48(100)	0(0)
Male condom	6(11,8)	45(88,2)
Quantity of contraceptive and preventive supplies:		
Pílula	15(20,6)	34(69,4)
Injectable	17(35,4)	31(64,3)
IUD	45(95,7)	2(4,3)
Male condom	7(14)	43(86)
Number of Laboratory Tests offered:		
Syphilis	12(24,5)	37(75,5)
Anti-HIV	13(26,5)	36(73,5)
Hepatitis B serology	17(34,7)	32(65,3)
Daily collection of laboratory tests in general / Referral	0(0)	42(100)

Immediate pregnancy test after menstrual delay	5(9,6)	47(90,4)
Prevention actions regarding STI/AIDS		
Professionals trained for the syndromic approach to STIs	29(55,8)	23(44,2)
Professionals trained in HIV testing counseling	9(18)	41(82)
Action for the attendance of the partner in case of STIs	3(5,9)	48(94,1)
Action for the attendance of the partner in case of HIV	2(4)	48(96)
Active search for users with STIs	1(1,9)	51(98,1)
Multi-professional team notifies positive syphilis test	13(25)	39(75)
HIV testing in the population any day of the week	33(64,7)	18(35,3)
HIV testing counseling	39(81,3)	9(18,8)
Average time for a positive HIV test to return to the unit is up to seven days	28(77,8)	8(22,2)
Approach with consent when asking for HIV testing	21(46,7)	24(53,3)

Source: Authors (2018)

In Marker 3, all the evaluated BHU perform treatment for candidiasis, and 51 (98.1%) perform treatment for trichomoniasis. However, 35 (71.4%) of the evaluated BHU do not administer Benzathine Penicillin in pregnant women with syphilis, as shown in Table 2.

Table 2 - Distribution of Basic Health Units according to Marker 3. Campina Grande, PB, Brazil, 2018

Responses to STI/AIDS treatment needs	**Does not meet n (%)**	**Meets n (%)**
Treatment with Benzathine Penicillin in pregnant women with syphilis	35(71,4)	14(28,6)
Administer penicillin to pregnant women with syphilis, without partner testing	33(63,5)	19(36,5)
Performs treatment of:		
Candidiasis	0(0)	52(100)
Syphilis	15(28,8)	37(71,2)
Trichomoniasis	1(1,9)	51(98,1)
Chlamydia	5(9,8)	46(90,2)
Care based on the syndromic approach	8(15,4)	44(84,6)

Source: Authors (2018)

Regarding Marker 4, it stood out as potentialities that all the evaluated UBS notify the diagnosis of syphilis in pregnant women and offer Pap smears to pregnant women as a standard procedure. As a weakness, about 21 (40.4%) of the evaluated BHU do not offer syphilis detection test to pregnant women in the 1st and 3rd trimesters of pregnancy and do not perform HIV detection test during prenatal care (Table 3).

Table 3 - Distribution of Basic Health Units according to Marker 4. Campina Grande, PB, Brazil, 2018

Prenatal and puerperium actions regarding STI/AIDS care	Does not meet n (%)	Meets n (%)
Scheduling of the first prenatal appointment is up to two weeks	2(3,8)	50(96,2)
Offers Pap smears to pregnant women as a standard procedure	0	52(100)
Offers syphilis detection test to pregnant women in the 1st and 3rd trimesters	21(40,4)	31(59,6)
Prenatal Hepatitis B detection test	6(11,8)	45(88,2)
Test for Hepatitis C detection for pregnant women	20(40)	30(60)
Prenatal HIV testing	21(40,4)	31(59,6)
Consenting approach to HIV testing request	19(38)	31(62)
Communicates HIV diagnosis through multi-professional team	6(12,8)	41(87,2)
Active search for the pregnant woman's partner with HIV diagnosis	4(8)	46(92)
Notifies pregnant woman of syphilis diagnosis	0	52(100)
Reference hospital for delivery of HIV-positive pregnant woman	1(2)	51(98)

Source: Authors (2018)

In Marker 5, 46 (92%) of the UBSs notify the diagnosis of HIV in pregnant women and 44 (91.7%) follow up the cases referred to the reference sector. The lack of scheduling in the reference sector of STI/AIDS, when the diagnosis is positive for HIV, stands out as a weak point in 29 (56.9%) of the BHU (Table 4).

Table 4 - Distribution of Basic Health Units according to Marker 5. Campina Grande, PB, Brazil, 2018

Integration of actions between UBS, CRT/SAE and maternity	Does not meet n (%)	Meets n (%)
Notification flow of congenital syphilis in the maternity ward	7(15,2)	39(84,8)
Notification of HIV diagnosis in pregnant women	4(8)	46(92)
Referrals and appointments in STI/AIDS reference (CRT and SAE)	24(48)	26(52)
Sends information to the unit after returning from referrals	10(21,3)	37(78,7)
Returns to the unit about the delivery of the pregnant woman with HIV	19(42,2)	26(57,8)
Scheduling in STI/AIDS reference, when positive for HIV	29(56,9)	22(43,1)
STI/AIDS referral/counter-referral flow	23(47,9)	25(52,1)
Follow up on cases referred to STI/AIDS referral	4(8,3)	44(91,7)

Source: Authors (2018)

In Table 5, the predominant degree (>50%) of the Markers ranged from low to medium programmatic vulnerability.

Table 5 - Distribution of Basic Health Units according to the degree of Programmatic vulnerability by markers. Campina Grande, PB, Brazil, 2018

STI/AIDS Vulnerability Markers	Vulnerability Scale		
	High %	Medium %	Low %
Infrastructure for prevention/assistance actions (n=38)	2(5,2)	21 (55,3)	15(39,5)
Prevention Actions (n=31)	2(6,4)	2(67,8)	8(25,8)
Responses to treatment needs (n=48)	0(0)	29(60,4)	19(39,6)
Prenatal and puerperium actions (n=44)	0(0)	3(6,8)	41(93,2)
Integration of actions between BHU, CRT/SAE (n=39)	4(10,3)	11(28,2)	24(61,5)

Source: Authors (2018)

DISCUSSION

In the analysis, it was identified that in most BHU, the nurse is the technical manager. Due to his entire training context, with emphasis on the leadership process, this professional is highlighted as fit for the function, for performing activities in the care and management dimensions in health services [8].

It is up to the nurse, as the technical manager, to focus on articulating the process of organization and functioning of the services, identifying the errors and problems that compromise the final quality of the work, developing in people the idea that they can improve, redefining the role of the nurse in the care and management of the service [11].

In this planning/management, the nurse technician in charge uses knowledge of biological, human and social sciences, information technology, administration and education [8]. The use of this symbolic capital constitutes an intentionally structured system, aiming to obtain social integration that will enable the elaboration of a consensus about reality whose outcome will be the reproduction of the social order [6].

Regarding Marker 1, the insufficiency of educational materials and other prevention inputs, such as IUD, corroborates the study conducted in the city of São Paulo [10]. This finding is worrisome because, for quality care, the availability of adequate structures is essential, covering physical areas, materials, equipment and facilities [12]. The lack of adequate facilities and inputs in the BHU ends up compromising the performance of practices and the achievement of work goals by health professionals, causing a disqualified service to the population, as well as actions of low reluctivity to health problems [13].

The symbolic violence, related to the difficulty of access to inputs and exams and the weaknesses in preventive actions, diverges from what is recommended by public policies and local regulations. When approaching this weakness in PHC care with the Bourdieusian theoretical contribution, it can be inferred that nurses learn a managerial *habitus* based on their knowledge and experience acquired using tools that enable them to care for/assist

users of the health system with safety, quality, efficiency and effectiveness. But in the social field of health, its agents occupy different positions, according to the unequal distribution of symbolic resources [8]. Thus, hierarchies defined by power relations are structured, and hierarchical ways of putting each person in the right place are built, conditioning them to reproduce inequalities and be agents of symbolic violence [6].

In Marker 2, regarding the prevention actions regarding STI/AIDS, the literature points out that it is essential the training of the professional who performs the counseling, allowing to understand and clarify the doubts of the individual, respecting their uniqueness [14]. In addition, it allows the achievement of all the objectives proposed by the counseling, keeping the service functioning properly [15], including the active search to prevent abandonment of the treatment and the improvement of adherence of those who miss treatment [16].

The symbolic violence is evidenced to the extent that the minority of BHU performs counseling for HIV testing, pre- and post-test, and respects the average time of seven days for the return of the positive result to the unit, weaknesses also found in an investigation conducted with 442 BHU of the PHC of a large city [10].

The non-performance of counseling for HIV testing is caused by several factors, such as the high demand and the dynamics of services, overload of activities developed by professionals [17], the existence of incomplete teams and turnover of professionals in the BHU[18].

The report of these weaknesses attests that vulnerability is a common phenomenon in the health area, since users who demand assistance may need care that depends on high technology to survive or receive a serious diagnosis and a perspective of a future life with chronic diseases, among other possibilities that require adjustment to a hospital environment and a therapy established by the health team and the organizational and institutional demands. This context establishes the vulnerability of these users, influences their actions, emotions, thoughts and convictions, and influences the actions and reactions of health professionals [19].

Regarding Marker 3, the fact that most BHU do not indicate treatment with Benzathine Penicillin for the partner of pregnant women diagnosed with syphilis, without request or test results, contradicts what is recommended by the Ordinance No. 3.161/ 2011[20]. The treatment of pregnant women and their partners is one of the biggest obstacles to the elimination of syphilis, representing a public health problem in several countries, such as China [21]. In Brazil, only 15.2% of partners of pregnant women with syphilis are properly treated, indicating difficulties in prenatal care [4].

According to a study, there are multifactorial barriers that prevent partners of pregnant women from adhering to syphilis treatment, such as lack of knowledge about the disease and its consequences, inadequate care, risks and vulnerabilities, low socioeconomic conditions, drug therapy, and treatment follow-up, and the nurse's role is essential [22].

It is understood that the health care practice reported in this study is internalized, affecting the way of seeing the world and experiencing social relationships. The way care protocols are not regularly followed characterizes a symbolic violence, in a non-tangible way, which is legitimized as a type of force or cohesion that affects people, producing social inequalities and precarious assistance.

In Marker 4, the detection, notification and communication of HIV-related diagnosis and the fragility in the offer of syphilis detection test and anti-HIV test in prenatal care corroborate the result of a study in São Paulo with health managers [10]. The anti-HIV test during pregnancy was verified in Rio de Janeiro with a 91.5% coverage, and the ideal coverage was 95% [23]. In a city in Rio Grande do Sul, the result of the coverage was only 16.5%, representing fragility in the health services offered [24].

In Marker 5, the fragilities of the reference and counter-reference process in this

study resemble those reported in a qualitative study conducted in the countryside of Rio Grande do Sul [25]. The findings corroborate the Bourdieusian contribution concerning the understanding that in social relations non-formal hierarchies are established that legitimize symbolic violence. To maintain the symbolic power, its holders defend interests and ideologies in complicity with those who do not want to know that they are subjected to it or even that they exercise it [6].

According to the discussion of the main results, it can be stated that, despite the positive implementation of some aspects related to STI/AIDS issues for the population, there are weaknesses that impair the quality of the assistance provided and the development of protective and coping practices, compromising the integrality as a fundamental component of health care for this social segment.

The limitations corresponded to the non-participation of 19 BHU in the study, as well as the incomplete completion of some questions in the questionnaire. However, the study achieves its objective, contributing to the progress of science in the area of public health nursing.

CONCLUSION

The units were identified as having medium programmatic vulnerability to STI/AIDS in relation to infrastructure, prevention actions, as well as treatment. The units showed low vulnerability in relation to prenatal and puerperium actions, as well as regarding the integration of actions. Therefore, despite some potentialities, the most frequent weaknesses indicate that primary health care is still permeated by symbolic violence in STI/AIDS assistance.

The study contributes directly from the perspective that the data can provide subsidies to managers and health teams involved in PHC in determining health care priorities, ensuring the development of preventive practices and confronting STI/AIDS.

REFERENCES

1. World Health Organization (WHO). Sexually Transmitted Infections (ISTs). [Internet]. Genebra: WHO; 2019 [accessed 13 fev 2020]. Available from: https://www.who.int/news-room/detail/06-06-2019-more-than-1-million-new-curable-sexually-transmitted-infections-every-day.

2. Nelson LE, Tharao W, Husbands W, Sa T, Zhang N, Kushwaha S, et al. The epidemiology of HIV and other sexually transmitted infections in African, Caribbean and Black men in Toronto, Canada. BMC Infect Dis. [Internet]. 2019 [accessed 15 fev 2020]; 19(294). Available from: https://dx.doi.org/10.1186/s12879-019-3925-3.

3. Workowski KA. Centers for Disease Control and Prevention (CDC). Sexually transmitted diseases treatment guidelines. Clin Infect Dis [Internet]. 2015 [accessed 15 fev 2020]; 61(supl.8). Available from: https://doi.org/10.1093/cid/civ771.

4. Ministério da Saúde (BR). Boletim epidemiológico de Sífilis – 2017. [Internet]. Brasília: MS; 2017 [accessed 25 fev 2020]. Available from: http://www.aids.gov.br/pt-br/pub/2017/boletim-epidemiologico-de-sifilis-2017.

5. Ayres JR, França Júnior I, Calazans GJ, Saletti Filho HC. O conceito de vulnerabilidade e as práticas

de saúde: novas perspectivas e desafios. In: Czeresnia D, Freitas CM, editores. Promoção da saúde: conceitos, reflexões, tendências. Rio de Janeiro: Fiocruz; 2003. p. 117-39.

6. Bourdieu P. O poder simbólico. 2. ed. Rio de Janeiro: Editora Bertrand Brasil; 1989.

7. Freeman R, Gwadz M, Wilton L, Collins LM, Dorsen C, Hawkins RL, et al. Understanding long-term HIV survivorship among African American/Black and Latinx persons living with HIV in the United States: a qualitative exploration through the lens of symbolic violence. Int J Equity Health [Internet]. 2020 [accessed 03 out 2020]; 19(146). Available from: https://doi.org/10.1186/s12939-020-01253-w.

8. Souza DF, Silvino ZR. The Sociology of Pierre Bourdieu: theoretical potential for the subfield of nursing. Rev bras enferm. [Internet]. 2018 [accessed 03 out 2020]; 71(4). Available from: http://dx.doi.org/10.1590/0034-7167-2016-0505.

9. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Departamento de DST, Aids e Hepatites Virais. Boletim Epidemiológico - Aids e DST 2017. [Internet]. Brasília: MS; 2017 [accessed 25 fev 2020]. Available from: http://www.aids.gov.br/pt-br/pub/2017/boletim-epidemiologico-hivaids-2017.

10. Val LF do, Nichiata LYI. Comprehensiveness and programmatic vulnerability to stds/hiv/aids in primary care. Rev Esc Enferm USP. [Internet]. 2014 [accessed 25 fev 2020] 48(spe). Available from: https://dx.doi.org/10.1590/S0080-623420140000600021.

11. Silveira TVL, Prado Júnior PP do, Siman AG, Amaro M de OF. Opinião dos enfermeiros sobre a utilização dos indicadores de qualidade na assistência de enfermagem. Rev. Gaúcha Enferm. [Internet]. 2015 [accessed 06 out 2020]; 36(2). Available from: http://dx.doi.org/10.1590/1983-1447.2015.02.47702.

12. Moreira KS, Lima C de A, Vieira MA, Costa S de M. Avaliação da Infraestrutura das Unidades de Saúde da Família e Equipamentos para ações na Atenção Básica. Rev cogitare enferm [Internet]. 2017 [accessed 03 out 2020]; 22(2). Available from: http://dx.doi.org/10.5380/ce.v22i2.51283.

13. Bousquat A, Giovanella L, Fausto MCR, Fusaro ER, Mendonça MHM de, Gagno J, et al. Tipologia da estrutura das unidades básicas de saúde brasileiras: os 5 R. Cad. Saúde Pública [Internet]. 2017 [accessed 27 fev 2020]; 33(8). Available from: http://dx.doi.org/10.1590/0102-311x00037316.

14. Neves CLAM. Capacitação em acolhimento e aconselhamento para testagem rápida para HIV [tese]. Natal (RN): Universidade Federal do Rio Grande do Norte; 2017.

15. Lima CV de, Bezerra JM, Leitão CPLS, Silva MES da. O enfermeiro como gerente da atenção básica: o modo de lidar com as dificuldades e limitações do Sistema de Saúde Pública. In: Anais da VII Mostra de Pesquisa em Ciência e Tecnologia DeVry Brasil; 2016 Maio p. 2238-2208; Belém, Brasil. Belém: DeVry; 2016.

16. Pereira FW, Kleinubing RE, Ilha S, Gomes GC, Souza MB de. Strategies for joining to the treatment for seropositive pregnant women to human immunodeficiency virus. Rev pesqui cuid fundam [Internet]. 2015 [accessed 01 mar 2020]; 7(3). Available from: http://dx.doi.org/10.9789/2175-5361.2015.v7i3.2796-2804.

17. Gomes ESS, Galindo WCM. Equipes de saúde da família frente à testagem e ao aconselhamento das IST, HIV-AIDS. Rev Baiana de Saúde Pública [Internet]. 2017 [accessed 03 out 2020]; 41(3). Available from: https://doi.org/10.22278/2318-2660.2017.v41.n3.a2376.

18. Zambenedetti G, Silva RAN da. Descentralização da atenção em HIV-Aids para a atenção básica: tensões e potencialidades. Physis [Internet]. 2016 [accessed 01 mar 2020]; 26(3). Available from: http://dx.doi.org/10.1590/s0103-73312016000300005.

19. Boldt, J. O conceito de vulnerabilidade na ética e filosofia médicas. Philos Ethics Humanit Med [Internet]. 2019 [accessed 03 out 2020]; 14(6). Available from: https://doi.org/10.1186/s13010-019-0075-6.

20. Ministério da Saúde. Portaria n. 3.161, de 27 de dezembro de 2011. Dispõe sobre a administração da penicilina nas unidades de Atenção Básica à Saúde, no âmbito do Sistema Único de Saúde (SUS). [Internet]. Diário Oficial da União. 2011 dez. 27; [accessed 11 mar 2020]. Available from: http://bvsms.

saude.gov.br/bvs/saudelegis/gm/2011/prt3161_27_12_2011.html.

21. Liu Z, Wang T, Liu Y, Wang A, Xie D, Kong F, et al. Evaluating the progress to eliminate mother-to-child transmission (MTCT) of syphilis in Hunan Province, China: a study based on a health service delivery model. Plos One [Internet]. 2018 [accessed 11 mar 2020]; 13(9). Available from: https://dx.doi.org/10.1371/journal.pone.0203565.

22. Vasconcelos MIO, Oliveira KMC de, Magalhães AHR, Guimarães RX, Linhares M do SC, Queiroz MV de O, et al. Syphilis in pregnancy: strategies and challenges of nurses of primary care for treat ment couple simultaneous. Rev Bras Promoç Saúde [Internet]. 2016 [accessed 11 mar 2020]; 29(supl). Available from: https://periodicos.unifor.br/RBPS/article/view/6409/.

23. Oliveira MIC de, Silva KS da, Gomes DM. Factors associated with submission to HIV rapid test in childbirth care. Ciênc Saúde Coletiva [Internet]. 2018 [accessed 15 mar 2020]; 23(2). Available from: https://dx.doi.org/10.1590/1413-81232018232.11612016.

24. Machado VS, Mizevski VD, Brand EM, Calvo K da S, Belinni FM, Duarte ERM, et al. Availability of rapid tests for syphilis and HIV at primary health care units of Brasil in 2012. Saúde em Redes [Internet]. 2017 [accessed 15 mar 2020]; 3(1). Available from: https://lume.ufrgs.br/bitstream/handle/10183/169445/001049038.pdf?sequence=1&isAllowed=y.

25. Brodani JE, Leal FZ, Potter C, Silva RM da, Noal HC, Perrando M da S. Challenges of referral and counter-referral in health care in the Workers' perspective. Cogitare enferm. [Internet]. 2016 [accessed 15 mar 2020]; 21(1). Available from: http://dx.doi.org/10.5380/ce.v21i1.43350.

HOW TO REFERENCE THIS ARTICLE:
França ISX de, Basílio EEF, Aragão J da S, Magalhães IM de O, Pereira A de BR, Coura AS. Programmatic vulnerability to STI/AIDS in primary health care: a *habitus* permeated by symbolic violence. Cogitare enferm. [Internet]. 2021 [accessed "insert day, monh and year"]; 26. Available from: http://dx.doi.org/10.5380/ce.v26i0.74976.

Received: 03/07/2020
Approved: 28/10/2020

Associate editor: Susanne Elero Betiolli

Corresponding author:
Emerson Eduardo Farias Basílio
Universidade Estadual da Paraíba – Campina Grande, PB, Brasil
E-mail: emersontpb201244@gmail.com

Role of Authors:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - EEFB, JSA, IMOM, ABRP
Drafting the work or revising it critically for important intellectual content - EEFB, JSA, IMOM, ABRP, ASC
Final approval of the version to be published - ASC
Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - ISXF