‘If you drink, do not have sex’: questioning the discourses in the offer of Post-Exposure Prophylaxis (PEP)

‘Se beber, não transe’: interrogando os discursos na oferta da Profilaxia Pós-Exposição (PEP)

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ABSTRACT Post-Exposure Prophylaxis (PEP) for HIV is a biomedical technology, offered in cases of sexual violence and occupational accidents since the early 2000s, with its offer expanded to situations of consensual sexual relations after 2010. Despite being classified as biomedical, its offer and execution is mediated by relational technologies, permeated by socially constructed meanings. This study aimed to question the discourses produced on the offer of PEP among health workers. The research is inspired by Michel Foucault’s genealogical perspective, based on the need to problematize power relations in the discourses and knowledge of health professionals who work with the implementation of PEP in a medium-sized city in the central region of Paraná. Twelve interviews were carried out with managers of the HIV/AIDS policy and workers in the services that offer PEP. The discourses about the PEP are discussed, highlighting both the right to access and expansion of preventive possibilities and the prescriptive discourses permeating and constraining its offer. In conclusion, it is pointed out the necessity to qualify the access to PEP, affirming it as a practice of freedom.

KEYWORDS HIV. Post-Exposure Prophylaxis. Desease prevention.

RESUMO *A Profilaxia Pós-Exposição (PEP) para o HIV constitui-se como uma tecnologia biomédica, ofertada em casos de violência sexual e acidente ocupacional desde o início dos anos 2000, tendo sua oferta ampliada para as situações de relações sexuais consentidas após 2010. Apesar de classificada como biomédica, sua oferta e sua execução são mediadas por tecnologias relacionais, perpassadas por sentidos socialmente construídos. Este trabalho teve como objetivo interrogar os discursos produzidos acerca da oferta da PEP sexual entre trabalhadoras de saúde. A pesquisa possui inspiração na perspectiva genealógica de Michel Foucault, com base na necessidade de problematizar as relações de poder a partir dos discursos e conhecimentos dos profissionais de saúde que atuam com a efetivação da PEP sexual em um município de médio porte da região central do Paraná. Foram realizadas 12 entrevistas com gestoras da política de HIV/Aids e trabalhadoras dos serviços que ofertam a PEP sexual. Discutem-se os discursos que permeiam a PEP sexual, colocando em evidência tanto o direito ao seu acesso e ampliação de possibilidades preventivas quanto os discursos prescritivos que perpassam e constrangem a sua oferta. Conclui-se que é necessário qualificar o acesso à PEP sexual, afirmando-a como uma prática de liberdade.*

PALAVRAS-CHAVE *HIV. Profilaxia Pós-Exposição. Prevenção de doenças.*

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Introduction

In the last decade, tackling HIV/AIDS has gained new characteristics, especially with the emergence of forms of care and technologies. Combined prevention can be characterized as a prevention and care strategy for HIV/AIDS based on the combination of biomedical, structural and behavioral interventions at individual and community level, taking into account specific contexts[1].

Therefore, the importance of offering prevention methods on a large scale and in great variety is understood. Combined prevention brings benefits when associated with structural interventions, and this combination of methods may reflect on the way individuals and groups deal with risks and prevention, since it strengthens autonomy in the face of the epidemic and also covers a greater number of people[2,3]. In addition to all prevention methods, knowing that HIV infection is more likely to occur through sex[4], in 2010, the Ministry of Health added a new possibility of prevention for HIV: Post-Exposure Prophylaxis (PEP). This method is a biomedical technology that has existed since 1999 in the Unified Health System (SUS) and consists of the use of Antiretrovirals (ARVs) for 28 days.

At first, PEP was intended only for health professionals who had suffered accidents with biological materials. In 2000, the technology was made available to victims of sexual violence, and only from 2010 onwards, it began to be offered in cases of consensual sexual intercourse[5]. The availability of PEP is considered a significant change in combined prevention technologies and in the recognition, by the Ministry of Health, of people's sexual rights, especially those belonging to vulnerable populations. Although policies to combat HIV have been involved in the field of sexual diversity since the country's redemocratization process – seeking a policy based on respect for human rights, including sexual rights – there is great difficulty in transforming this policy into daily action within the SUS[4,6].

In addition to taking sexuality into account in the context of biomedical prevention technologies, it is important to detach the risk caused by sexual practice and to connect to one's Rights. In the first Clinical Protocol and Therapeutic Guidelines (PCDT) for PEP, which was in effect until June 2015, the analysis for recommending or not Antiretroviral Therapy (ART) refers to the context of the exposure. The professional should check three main aspects about the patient/candidate for prophylaxis: the serology of the source patient, the type of sexual practice and the prevalence of HIV infection in the population segment to which the partner belongs[3].

As of June 2015, the protocol has been simplified. Prophylaxis began to be recommended by assessing the risk of exposure, and no longer by category and context of exposure. Thinking about comprehensive health care for people exposed to Sexually Transmitted Infections (STIs), current guidelines recommend analyzing the answers to four questions asked to all potential users of PEP: the type of material to which the person exposed himself; the type of exposure; the time elapsed between exposure and consultation; and the patient's serology[3]. Based on the responses, the professional assesses the need for PEP prescription.

After simplifying the PCDT, the Ministry of Health launched the Guidelines for the Organization of the Post-exposure to HIV Infection Antiretroviral Prophylaxis Network[7]. This document aims to standardize some actions for the provision of PEP in the public health network, arguing that, with the simplification of the PCDT, the participation of the specialized professional becomes expendable, making it possible to diversify the places where prophylaxis can be provided[7]. In this sense, the experience of municipalities such as Florianópolis (SC)

stands out, which initiated the decentralization of HIV/AIDS care, including the provision of PEP in primary care, from 2015[8].

PEP is a biomedical technology that consists of the use of controlled drugs, which can be appropriated in different ways, as a political resource with the aim of guaranteeing or detracting sexual rights; what is at stake is whether or not it is understood as the result of a policy based on respect for human rights. To avoid health risks and guide decision-making, it is necessary to analyze the situation of exposure of the user to HIV through a detailed account of the practice that led him/her to seek PEP. However, it is noticed that health workers have difficulty in addressing sexual practices, as well as patients have difficulty in reporting them, which demonstrates that the subject of sex is not natural. In addition, many health professionals, despite working in public programs focused on sexuality, end up acting based on personal values, mixing scientific, religious, moral and other knowledges[9]. Another aspect to be analyzed is that, although PEP is considered a biomedical technology, access to it is permeated by relational technologies and various psychosocial aspects. In this sense, PEP can be read not only as a biomedical strategy, but as a strategy in service of different forces, according to the uses of it by the professionals involved.

The best prevention methods will always be those that suit the needs of users and that consider the contexts in which they are inserted, being even more advantageous for providing the means for structural and individual interventions[3]. When structuring a Pedagogy of Prevention[10], researchers from the Brazilian Interdisciplinary AIDS Association (ABIA) state that, in order to be effective in offering multiple preventive approaches, it is necessary to guarantee access and information about what is available and the effectiveness of each method, allowing that individuals at risk of exposure receive more than pills in their bodies, but that they feel empowered by the decision to prevent themselves in the way that makes the most sense[10].

It should be noted that sexuality continues to be approached hegemonically from the perspective of risk, and not as a right, understanding sexual practices and experiences as a problem that can lead to AIDS; in this logic, a behavior classified as deviant or transgressive can lead the subject to be infected by a virus. Such convictions influence health professionals to seek control over people's sexual lives, making it impossible to work based on the perspective of sexuality as a right[4].

Lima, Almeida and Vieira[11] sought to think about AIDS medication and adherence to ART from a biopolitics perspective, criticizing the Brazilian model of care for not welcoming patients or considering their singularities, which leads to the prescription of general conducts and distances the patient from protagonism and from the right to his own body. For the authors, with the emergence of AIDS, the challenge of thinking about public health policies that do not lead to a reduction of human subjectivity and sexuality to biomedical discourses has grown[11].

In view of this, the notion of device[12] will be used as a tangle of knowledge-power established between discourses, institutions, decisions, laws, scientific assumptions, between what is said and what is not said, and its understanding is of fundamental importance for the analysis that is intended to be developed in this article. The device is a versatile concept, which will be used to understand sexuality and AIDS intertwined in the power relations between the State as an overseer of the bodies of people who (co) exist or may potentially be exposed to HIV.

In 'The history of sexuality: the will to knowledge', Foucault[13] seeks to define the Device of Sexuality, which could be described as something that links the

stimulation of bodies, the intensification of pleasures, the incitement of discourse, the formation of knowledge, the reinforcement of controls and resistance based on great strategies of power and knowledge and discursive procedures; part of a transformation scheme that needs to be understood as a global strategy that depends on precise and tenuous relationships of support and fixation, articulated in the discourses that convey and produce power, but also undermine it, and in the secrets and silences that, in the same extent, they shelter and prohibit and loosen ties, giving rise to tolerances. There is, in fact, no censorship of sex, but incentives for the production of discourses about it, with an emphasis on the licit-illicit duality[13].

In addition, Michel Foucault allows sex to be denaturalized, showing that no relationship would be – although generally monogamous – just between two people. The State is part of these relationships, seeking to control sex, defining which is good and which is bad, in search of sanitization of practices considered risky to life.

Néstor Perlongher[14], based on Foucault's studies, coined the term AIDS device, which is related to what he calls the 'old confession', but now in the office it is time to talk about sex. According to the author, this device refers to

> [...] not the disease itself, but the moralization triggered around it [...] requires as a prerequisite that everything related to corporeality can be said, shown, exhibited, assumed; from this it is possible to diagnose and regulate [...][14(74)].

For this regulation to be possible, the AIDS device is exercised when medical councils seek to discipline sexual practices, "especially homosexual ones"[14(70)]. The control that the State operates, when it pays attention to the use of the bodies and pleasures, implies that some enjoyments are more legitimate than others, attributing the accusation of irresponsibility to individuals who are part of a 'risk group' instituted by convergences, affinities and homogenization of interests, which is the cause of contamination and therefore needs to be sanitized. In view of this, it is necessary to problematize these hygienist and stigmatizing practices that affect not only people living with HIV but also all others considered by the State as part of a more vulnerable population.

That said, it is emphasized that public policies on HIV are advances, from the point of view of asserting the right and access to citizenship, but they must be problematized, especially by the forces of subjection that they can produce: if, on the one hand, they undertake efforts to make positive seropositive identities, on the other hand, the Aids device brings in its memory stigmatization processes that are still strong, acquiring confessional traits[13] and, in a way, disciplinary instruments that the State appropriates.

Therefore, this research aims to question the discourses produced about the offer of sexual PEP among health workers in a municipality in the central region of Paraná.

Material and methods

This study uses data from a larger study entitled 'Reacting to HIV: post-sexual exposure emergency care in the services of a city in the central region of Paraná', linked to the master's thesis defended and supervised respectively by the first and second authors of this article . The research had a qualitative bias, inspired by the genealogical perspective of Michel Foucault: "Foucault's genealogical period is mentioned to refer to those works dedicated to the analysis of the forms of exercise of power"[15(184)]. The choice was justified by the need to problematize power relations based on the speeches and knowledge of professionals who work with the implementation of sexual PEP.

The research had its data produced between July 2019 and November 2020 in a medium-sized municipality, in the range between 150 and 200 thousand inhabitants, in the central region of the state of Paraná. The participants were two professionals representing the management of the Department of Specialized Care, which manages the HIV policy in the municipality, the manager and the health professionals who work at the Specialized Care Service/ Serological Guidance and Support Center (SAE/COAS) and the nurses and the doctor who act as on-duty physicians in the municipal urgency and emergency units and in emergency care related to sexual exposure to HIV. For this article, the sample was made according to *table 1*:

Table 1. Interviews carried out

Identification in the text	Job	Profession/training	Workplace
Manager 1	SAE/COAS Manager	Nursing	SAE/COAS
Manager 2	DAES manager	Speech therapy	DAES
Nurse 1	Primary Care Nurse and Nurse on Duty in the Emergency Unit	Nursing	UBS / Emergency Unit
Nurse 2	Primary Care Nurse and Nurse on Duty in the Emergency Unit	Nursing	UBS / Emergency Unit
Nurse 4	SAE/COAS nurse	Nursing	SAE/COAS
Physician 1	Primary Care Physician/Physician on duty in the Emergency Unit	Medicine	UBS / Emergency Unit
Nursing technician 1	Nursing technician at SAE/COAS	Nursing technician	SAE/COAS

Source: Own elaboration.

The research project was approved by the Research Ethics Committee of the State University of the Midwest, Campus Irati, under opinion number 3,417,298, of 06/26/2019. Participation in the interview only occurred after signing the Free and Informed Consent Form.

As an analysis method, the study was based on Foucault's Discourse Analysis. Since it was never one of Foucault's projects that there was a theory of discourse analysis, the author only considered that his work should be treated as a toolbox: in this box, discourse is a founding concept of his thought, articulating an entire conceptual system that runs through, but is not limited to, language. This means that discourse materializes in the form of text, image, verbal and non-verbal languages, always under historical determinations[16].

To reach this line of analysis, the interviews were read, first in the order in which they occurred, which made some speeches stand out, and – as they were being related to the research objective – we started treating them as a line of analysis; in a second moment, as the analysis was carried out and the speeches of the interviews were integrated with the theory, we returned to the reading of the interviews, so that the actions complemented each other.

The discursive production on AIDS and sexuality as a device to manage bodies

According to Manager 1's report, historically, the SAE constitutes a centralized reference for the provision of PEP in the municipality. According to the professional, whenever there was an exposure situation, the SAE was called in to assist the patient. To cover the weekends, there was a shift, in which the professionals were called and carried out all the assistance related to PEP, regardless of the motivation: whether occupational, due to sexual violence or through consensual sex.

Also, according to Manager 1, this on-call system was no longer in use around 2014. Then, in 2015, the PEP PCDT was simplified. This same participant reports the perception that, from 2016/2017, the demand for PEP increased, coinciding with the expansion of its access to municipal emergency services, culminating in the current care configuration.

There are, therefore, two types of service in the municipality where the user can seek the PEP: the SAE/COAS and the Municipal Emergency Units. The SAE service is from Monday to Friday, during business hours; two of the emergency units are open 24 hours a day and 7 days a week, and the third is open from 7 am to midnight, from Monday to Saturday. If the exposure takes place on weekdays, the patient is always advised to seek the SAE/COAS – even if the exposure occurred during the night or at dawn –, instead of receiving care in the emergency units. It should be noted that the guidelines of the Ministry of Health for PEP recommend that the first dose of the drug should preferably occur two hours after exposure, and cannot exceed 72 hours.

The flow for the PEP, when the patient seeks it at the SAE/COAS, was described by Manager 1 (2019): when the user does not bring the partner, the HIV test is performed and, when the result is 'no reagent', the patient goes to the doctor, who prescribes the prophylaxis. When people come together, they are all tested, and efforts are made to avoid prescribing prophylaxis due to possible side effects.

After this contextualization about the offer of PEP in that municipality, we move on to the analysis of some excerpts from the interviews, in which we could observe the experience reports of the health workers mixed with what they heard from the users they attended. Therefore, we intend to analyze the discursive production of care and control of bodies through the research participants' gaze. The following clipping deals with a service that resulted in the use of sexual PEP and was an experience reported by a nurse on duty at the emergency unit:

> *In fact, we never know 'the real' situation, sometimes they speak the truth, but not always. But the girl told me that she had gone out, didn't know the person, went to the club and had sex with the person without using a condom. She said that at the time she didn't think about it, but then she got scared because she realized that the guy had the relationship with her and right after that he left her and went with another girl. Then she thought 'Well... he must have had many other relationships before me!'. So, she got scared and looked for the emergency room, we only did the HIV test, thank God it was negative, we did the counseling and we advised her to seek the SAE to do the other tests as well. The girl was very worried and afraid, and so, we advise and such.* (Nurse 2, 2019).

These are the facts narrated from the nurse's point of view; it is possible to verify that the patient felt the need to justify that "*at the time she did not think*". Another important detail of the statement is right at the beginning, when the nurse says "*we never know the 'reality' of the situation*", referring to the impossibility of knowing if the patients are telling the truth. It is important, however, to emphasize the difficulty, in a quick relationship such as emergency care, to make this type of inference, since there is still no link between patient and worker, and a relationship of trust must be

built. It is worth highlighting the presence of objective parameters: the PEP PCDT establishes that, when the result of the rapid HIV test is inconclusive, PEP must be prescribed and provided to the patient. Bringing this to the case narrated by Nurse 2, it is perceived the need for a careful listening to the patient's story, which will establish – together with the criteria contained in the PCDT of the PEP – the bases for the decision on the prescription.

Nurse 2 concludes the previous report by saying:

> *But it seems that there is no fear beforehand, there is fear afterwards, fear after the relationship and the possibility of having been contaminated and such. She got lucky! Because if it's positive then it's too late.* (Nurse 2, 2019).

This second part of the worker's speech can be analyzed from two perspectives: the first concerns fear, and the second, luck. Returning to the research carried out by Paiva[9], the person interviewed, L. (1987) says:

> The moment I caught the AIDS virus, I wasn't there contaminating myself... it was a lot of passion! It was a moment of joy, of pleasure, so long desired... Bodily pleasure, but also spiritual. I wanted to experience that love of mine, repeat other moments like that[9(642)].

Thus, it is not a universal assumption that a person thinks about HIV, AIDS or other STIs at the time of sex; so, in fact, it is understandable that fear only comes later, being the role of the health professional to address the events of everyday life, including sex. The discourse expressed in the professional's speech is linked to a normative assumption: when having sex, people should think about illness and, therefore, prevent themselves. What is 'outside' this normativity seems surprising. Sexual PEP, however, precisely incorporates the possibility that this 'taking care of it later' is embraced by health actions that also enable a form of prevention. The Brazilian HIV prevention policy has been centered, throughout its history, on offering the male condom as the main prevention tool[17], shaping a preventive culture. However, in the 2010s, there was an increase in the range of preventive options, represented in the image of the combined prevention mandala[18], which consists of a set of strategies with different combination possibilities, aimed at expanding the autonomy and protagonism of the subjects in the construction of prevention. They require a reconfiguration of the preventive culture: while the condom involves 'arriving before intercourse' (it is necessary to have the condom and insert it before penetration) to effect prevention, PEP comprises 'arriving after intercourse', but before the infection process occurs. Thus, it requires a twisting of the meaning traditionally attributed to prevention. Perhaps for this reason, many professionals forget about PEP and consider that there is nothing else to do when someone reports unprotected sexual intercourse.

The second discursive aspect is how lucky the patient was not to have been infected with HIV, which is not just a possible assumption to know, since she took the quick test on the day of exposure in the emergency unit and, according to the informed protocol, was not monitored by the emergency unit, but by the SAE or the Basic Health Unit. There are several motivations for people to have sex without a condom, one of which is the imminent possibility of being infected with HIV[19].

Another aspect addressed with the research participants aimed to understand the approach to potential PEP users. According to one of the participants:

> *Yeah... We ask what her sexual behavior is, if she usually has several partners, if that night she was with others too, right? And then she ended up saying that it wasn't just him that night, that he was with another guy too, because he had been drinking and all. Then we get a little more worried and we even advise and guide more incisively to seek the SAE. Now if the person went there, that*

we don't know, right? But we advise them to go. (Nurse 2, 2019).

The doctor's speech about how to provide care to a person who has been exposed to HIV and who could use PEP illustrates this:

I don't remember half of it anymore, but I know more or less what it's like. But we do our consultations, we have our tools and medical applications to consult. Because having everything like that on the top of your head... these are things that we don't do every day. We are not caught so off guard if we have to. (Physician, 2019).

The worker mentions a tool that until then had not been addressed by other professionals: a mobile application. The Ministry of Health[7] refers to the simplification of the PEP protocol as the institution of a single algorithm for all types of PEP; both the excerpt from the doctor's speech and the Ministry of Health document denote a rational/administrative implication, with emphasis on the use of tools that enable the objectivity of care, configuring this topic as just another subject to be addressed, like any other, in an aseptic way.

This asepsis is countered by other statements, such as the following:

And we know that then they put other people to deliver the medication, the nurses in the emergency units needed training to do the test; the doctor, we took the protocols, left them on the doctor's desk so that he would know that this is a medical emergency. But, sometimes, the patient still comes here on Monday and says that he was not seen [at the emergency room]. (Manager 1, 2020).

It is important to consider that, unlike the team at the specialized HIV/AIDS service, the team at the emergency care services is characterized by a greater diversity of professionals, in shift schedules, configuring greater turnover and difficulty in carrying out permanent education processes.

Still, the professional's speech about the initial resistance of some professionals in relation to the implementation of PEP in emergency services stands out:

We had a lot of resistance from the physicians, because they didn't want to admit that this was a medical emergency until we showed 'it's written here, look' . (Manager 1, 2020).

The speech of another professional shows that the flows and understandings around PEP in emergency services are not yet settled in the daily life of emergency units:

I've had a lot of patients who didn't take the PEP, came back here and said: 'I'm not going to take it because I'm not going to sit there for 3, 4 hours waiting'. So, about this subject, we went several times to talk to the doctors and nurses, so it seems that now it's almost a little better, we don't have so many complaints; but when I came back from the pandemic, I remember that the pharmacist commented to me: 'we have to talk to the UPA people again, because there are a lot of people coming back, saying that they are not being attended to or that they have not received the medication, and the medication was there'. (Manager 2, 2020).

Complementarily, in the interviews with nursing professionals, it was observed that there is no consensus on the classification of the waiting time of people who access the units in search of the PEP. This shows that, even with the existence of protocols and guidelines, the guarantee of access to PEP in a timely manner and the approach to counseling do not always occur, resulting in patients arriving at the SAE after the possible deadline for prescription of PEP has expired.

In some interviews, more was heard about how the professionals carry out the approach:

Is easy. It depends a lot on whether you have experience, routine. I always tell the people we are training that the first counseling, the first positive test we never forget, because we go... leave it at

> *home, keep our prejudices away to hear things that, suddenly, for you is a absurd thing, but for the patient it is a normal thing. So we have to try... sometimes people talk right away about what happened, how the relationship was, the condom broke, didn't break, didn't use it, how it was, the type of relationship, and at other times we have to go through the edges to try to reach the goal, so it varies from each person. Over time, with the experience that we accumulate, we realize how you manage to achieve the goal in the best way.* (Nurse 4, 2020).

This speech has an instituting potential in relation to the processes of permanent education in health, both because it refers to the light technologies involved in care and because of the need for professionals to identify their prejudices or other aspects that interfere with care. If counseling is an intersubjective relationship, the professional's reactions and approach will also affect the user, allowing greater or lesser openness to dialogue. Thus, it is imperative to include this aspect in the training of health professionals. It is important to emphasize that this speech contrasts with the asepsis denoted in the speech of the physician and Manager 1 previously exposed, which highlighted the more formal dimensions of the process.

It is necessary to consider that, although PEP is configured as a biomedical technology, the access and approach to it are characterized as a light, relational technology[20]. Thus, the application can indicate the biomedical perspective, but the relationship must be produced in the meeting, in a unique way, taking into account the complexity surrounding issues involving sexuality and its multiple meanings.

Continuing with the analysis and understanding of the aspects that permeate the PEP offer, it is observed that several professionals reported a common attitude among patients: the request for privacy since the reception. According to Nurse 2 (2019),

> *It is not our habit to close the door during the* [risk] *classification, so when the patient asks, you already understand that it is something different that he wants to tell you.*

Nurse 1 also shows concern about exposing the patient:

> *But in the risk classification, the patient is often very exposed, because the nurse and the technicians stay. So, when it's a case like that, we try to go to a room, reserved, with the patient and so on... so as not to expose the patient, right?* (Nurse 1, 2019).

These situations and requests express a discourse that relates sex and sexuality with intimacy and privacy. Therefore, they need to be spoken behind closed doors, or in a lower voice. It is understood, therefore, that this is not discussed as any other subject, constituting forms of expression of the device of sexuality.

Within the aspects discussed so far, it can be said that health practices are part of a game of captures and resistances. By problematizing these discourses from the forms that have been observed so far, we seek to make a statement about the need to create or expand conditions of resistance, opportunities for identities and behaviors to be legitimized, and not judged. One might think that health workers prescribe, in addition to condoms and ARVs, a sexual diet, but it is recalled that the existence of a power relationship is inseparable from the possibility of resistance. A speech that drew attention is expressed as illustrative of what this prescriptive discourse is:

> *We always guide and always talk, right? What I always say to everyone, men or women: if you're going out drinking, don't have sex. When you go out wanting to have sex, just go out for that. Drinking and sexual intercourse don't mix, it doesn't work. Because sometimes, you see... most relationships end up not working out very well, the condoms break, that happens, it's because that you mix drink and sex and it doesn't work.* (Nursing Technician 1, 2020).

This speech is crossed by a prescriptive and normative perspective: 'if you drink, don't have sex'. It starts with prescriptions, rather than with attempts to understand or seek to construct, with the subject, what is the best and/or possible for him, understanding that the aforementioned prescriptive discourse could be inscribed:

> [...] in the classic models for explaining the health-disease process, assumptions that support the prescription of technically justified behaviors as the only possible choices for achieving the well-being of all individuals, regardless of their socio-historical and cultural insertion. In this path, the it was incorporated into our sanitary culture the assumption that 'uneducated' behaviors by these standards are insufficient, unhealthy and inadequate (both from a technical-sanitary and moral point of view), constituting what has been called, contemporaneously, as 'risk behavior'[21(1336)].

Thus, it is understood that

> [...] the support and social response that is sought involves communication between different people, which does not aim at homogenizing ways of thinking and lifestyles, but the construction and strengthening of complicity in the search for protection[21(1336)].

It would be possible, then, to associate this with the statement of freedom for Foucault, which only exists based on power relations. Castro[15] compiles and explains how freedom works for Foucault:

> Qualified as free those forms of relationship between subjects that, negatively, are not blocked and, positively, those in which an open field of possibilities is available; that is, relationships that are susceptible to modification[15(246)].

The prescriptive speech, present in the worker's instruction, can be heard by several subjects, that are free to follow or not, that can be captured or resist. It is important to emphasize that, in the relationships that are conceived by processes of freedom, one places oneself next to the other, not in the place or on top of the other, seeking to build relationships of dialogue, that help to think about oneself (not to prescribe to the other), recognizing the leading role in the production of health. This perspective dialogues with the reduction of harm and risk, envisaged as one of the approaches expressed in the prevention mandala[18]. From this perspective, it is possible to expand possibilities that protect the subject, based on what is within their reach, their conditions and needs.

Final considerations

The study found that the PEP was implemented in the municipality, expanding the possibilities of HIV preventive strategies for the population. Despite this, there are still aspects that constrain the offer of PEP, highlighting controversies around its classification within the risk classification criteria and situations in which users did not obtain care in emergency services, resorting to the SAE/COAS after the end of the deadline for prescription of PEP.

Public policies are crossed by a game of socially constructed forces and discourses. Just as many of these discourses convey acceptance, not judgment, participatory bias, there are also prescriptive discourses: 'if you drink, don't have sex', forging a sexual dietetics and insinuating itself on the bodies of health professionals and users of health services, opening a field of possible experiences in this game of forces.

The need for a reconfiguration of the preventive culture is indicated, incorporating

the notion of combined prevention, in which the condom is just one of the prevention strategies among several available, with emphasis on PEP. It is defended that it be offered as a way to expand the relations of freedom, allowing the subjects to maximize their degrees of autonomy and protagonism in the effectiveness of prevention.

Collaborators

Paula WNC (0000-0002-9714-2616)* e Zambenedetti G (0000-0002-7372-9930)* contributed equally to the elaboration of the manuscript.
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