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RESEARCH

A oferta do teste anti-HIV às usuárias das unidades da rede básica de saúde: diferentes abordagens dos profissionais

The offer of the anti-HIV test to the users of the health basic net units: different aproaches of professionals

La oferta del teste anti-HIV a las usuárias de las unidades de la red básica de salud: different approaches de profesionales

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ABSTRACT

Objective: To identify and describe the behaviors of health professionals in the offer of anti-HIV test; to analyze the practices of professionals from the accounts of users of the basic health services. **Method:** descriptive, qualitative study with 40 women attended at 08 Municipal Health Centers. **Results:** the discursive production of the interviews was subjected to Alceste program, constituting two categories of analysis. The first includes approaches in individual care in the MHC network of Rio de Janeiro describing the three modes of conduct of health professionals during the provision of HIV testing. The second category refers to the approaches in collective care, which shows that the counseling activities do not occur uniformly. **Conclusion:** the results point to a practice that distorts what is recommended by official programs in relation to the Counseling Programs. **Descriptors:** HIV/AIDS, Women's health, Counseling, Alceste.

RESUMO

Objetivo: Identificar e descrever as condutas dos profissionais de saúde na oferta do teste anti-HIV; analisar as práticas dos profissionais a partir dos relatos das usuárias dos serviços da rede básica de saúde. **Método:** é um estudo descritivo, qualitativo, com 40 mulheres assistidas em 08 Centros Municipais de Saúde. **Resultados:** a produção discursiva das entrevistas foi submetida ao programa Alceste, constituindo duas categorias de análise. A primeira contempla as abordagens no atendimento individual na rede de CMS do Rio de Janeiro descrevendo os três modos de conduta dos profissionais de saúde durante a oferta de teste anti-HIV. A segunda categoria refere-se às abordagens no atendimento coletivo, onde se observa que as atividades de aconselhamento não ocorrem de maneira uniforme. **Conclusão:** que os resultados apontam para uma prática que se desvirtua do que vem sendo preconizado pelos Programas oficiais em relação ao Aconselhamento. **Descritores:** HIV/Aids, Saúde da mulher, Aconselhamento, Alceste.

RESUMEN

Objetivo: Identificar y describir las conductas de los profesionales de salud en la oferta del teste ante-HIV; analizar las prácticas de los profesionales a partir de los relatos das usuarias de los servicios de la red básica de salud. **Método:** estudio descriptivo, cualitativo, con 40 mujeres asistidas en 08 Centros Municipales de Salud. **Resultados:** las entrevistas fueron sometidas al programa Alceste, constituyendo dos categorías de análisis. La primera, las abordajes en la atención individual en la rede de CMS del Rio de Janeiro describiendo los tres modos de conducta de los profesionales de salud durante la oferta de teste ante-HIV. La segunda se refiere a los abordajes en la atención colectiva, donde se observa que las actividades de consejo no ocurren de manera uniforme. **Conclusión:** los resultados apuntan para una práctica que se desvirtúa del que viene sendo preconizado por los Programas oficiales en relación al Consejo. **Descriptores:** HIV/Aids, Salud de la mujer, Consejo, Alceste.

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INTRODUCTION

Since the 90s, women have been in evidence in the field of health, constituting the focus of attention in public policies as a result of acquired immunodeficiency syndrome (AIDS). Cases of infection with the human immunodeficiency virus (HIV) were detected among women early in the epidemic and, from the second half of the 80s, epidemiological data have already proven the vulnerability of this population, whose profile was called feminization of AIDS.

Throughout these years, the AIDS epidemic has been presenting distinct aspects from those in early 80's, with characteristics of poverty, interiorization, heterosexualization and feminization. Regarding this last aspect, it is observed that there has been a growing trend of infection for women in stable heterosexual relationships. It is also observed that they live in social contexts in which various factors potentiate their vulnerability to sexually transmitted diseases (STDs) and AIDS, such as gender-based violence, poverty, poor education, etc.[1]

Thus, the feminization of AIDS affects not only the violence to which they are subjected, but other factors that affect a large percentage of women in our country. Evaluating the profile of these women, it is noted that they are poorer, less educated, black and brown, infected heterosexually and with only partner.

From the 1990s the number of cases among women began to show an accelerated growth and notification of AIDS rose from 4.2% in 1985 to 28.1% in 1993, rising to 48.2% in August 1999.[2]

Given the epidemiological scenario presented in the early 90s, in 1994 the Ministry of Health, through the National Program of STD/AIDS (NP-STD/AIDS), along with researchers and feminist activists, started to discuss the dimensions of this problem and define more effective strategies for prevention and control for this group. However, it seems clear that the intensification of measures was performed much more because of the increase of HIV infection in children, as a result of vertical transmission of the virus than because the other implications on the lives of women, arising from the process of feminization of AIDS.

With consequent increased risk of vertical transmission of HIV, the Ministry of Health, through the NP- STD/AIDS started to encourage, from the second half of the 90s, the offer of HIV testing, accompanied by counseling to female in prenatal care.[3] This practice was first introduced in Brazil by non-governmental organizations and then went on to be performed by the public sector in the Counseling and Testing Centers (CTC). Subsequently, in view of the changes in the epidemiology profile of AIDS, there was decentralization of this practice for specialized care services, and finally to the basic health units.[4]

Counselling is the opportunity of information about AIDS and clarification regarding the treatment, ensuring the right of knowledge and the choice of how to act in situations of seropositivity for HIV.[3] The offer of HIV testing during pregnancy should occur

concomitantly with pre and post-test counselling in order to support the pregnant woman's decision with regard to the performance or nonperformance of the test.

Thus, the practice of counseling presupposes interpersonal professional/client relationship that favors rescuing the internal resources of the individual served, so it can be recognized as a subject of its own health. Thus, it aims to promote reflection that enables this individual to realize its own risk, to make informed choices and to adopt safer practices.[5-6] It is a practice that appears to help, in which the conversation is structured as an interview. Basic components to the process of counseling are: educational support in exchanging information on STD/HIV/AIDS, its modes of transmission, prevention and treatment; emotional support; and risk assessment leading to a reflection on values, attitudes, behaviors and strategies to reduce risk.[6-7]

Counseling is a complex and preventive practice because it configures a moment of dialogue, in which the professional should be able to realize the subjectivity, being upgraded, promoting health education and discussing preventive and informative issues that may improve quality of life and health of the person seeking the exam. We understand, therefore, that the counseling, while related to the educational process, with a preventive look, is directed to the clarification of the problem.[8]

Through the empirical observation of the development of counseling in HIV/AIDS in health services, it was evaluated the need to investigate how professionals carried out this practice in everyday care services to the female group. Therefore, in this study, it was defined as an object of study the approach used by professionals in the offer of HIV testing for women in assisted in Prenatal Assistance Program services of basic health network of the municipality of Rio de Janeiro. To conduct the study, we defined the following objectives: to identify and describe the behaviors of health professionals in the provision of HIV testing; to analyze the practices of counseling of professionals from the accounts of users of the basic health services.

The study is considered relevant to the extent that, from the accounts of users, it is possible to get an overview of the development profile of the practice of counseling within the municipality, and it may serve as a basis for the evaluation of this practice. It may therefore be useful to improve it or make it to develop as recommended in the context of attention to women's health and the prevention of HIV infection, from the perspective of State policy and the needs of society. The study is evaluated as relevant since it can serve as a basis for other similar studies in which the approach of professionals is extremely important for the customers to make their choices consciously and clarified.

METHOD

This is an exploratory and descriptive study with a qualitative approach, carried out in the municipality of Rio de Janeiro, in the Municipal Health Centers (MHCs) pertaining to the basic health network, totaling eight (08) units. We opted to choose units located in all

geographic areas, from Planning Areas as defined by the Municipal Health Office of Rio de Janeiro, with the intention that the results are qualitatively representative of the municipality.

The study was developed with a group of forty (40) women attended by the Prenatal Program of MHCs. Inclusion criteria were related to age (from twenty years old) and to the number of times that they have been attended in that Program (more than four visits).

Data were collected through semi-structured interviews in the period from July to August 2006, after approval by the Research Ethics Committee of Pedro Ernesto University Hospital of the State University of Rio de Janeiro, which approved under the Protocol CAAE: 0047.0.228.000-05. Furthermore, we applied the Informed Consent Form, ensuring the provisions of Resolution 196/96 of CONEP, in effect at the time.

Interviews were recorded, originally transcribed and subsequently stored together in a single Word file, with no gaps between them, being, however, identified in their begging with four asterisks and the variables that characterize each deponent. The preparation of this *corpus* also included the standardization of expressions, correcting words and the substitution of colloquial terms for more formal terms, without, however, changing the meaning of the text.

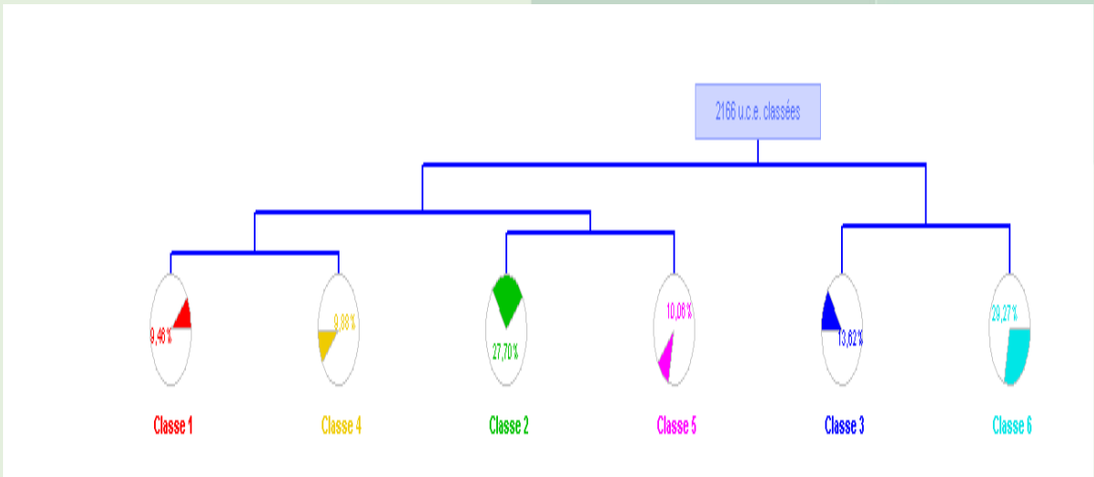
The *corpus* containing the discursive production of the deponents was analyzed by ALCESTE program (lexical analysis by context of a set of text segments), which identified 40 lines with asterisks, corresponding to the amount of analyzed interviews. After that, the program performed the lexical analysis through quantitative techniques of textual statistics in five steps that comprise its operation, providing in the end categories of analysis.

RESULTS E DISCUSSION

Regarding the study participants, its majority composition was characterized by: age between 20-29 years old; not developed remunerated activities; professed the Catholic religion; living with a single partner; living in the North and Central areas of the municipality of Rio de Janeiro; used MHC most often in the last five years.

Regarding the discursive production of the deponents, ALCESTE program divided the *corpus* analysis in 2,166 elementary context units (ECU), containing an average of 19 words in each ECU, which correspond to the smallest fragments of speeches cut by the software. After this procedure, it conducted automatically, lexical analysis of the text, generating a dendrogram with six classes or categories of analysis, divided in pairs, showing the complementary relationship existing between them, as follows: Classes 1 and 4; Classes 2 and 5; Classes 3 and 6, as seen in Figure 1.

Figure 1 - Organization of the classes in the Dendogram of Descending Hierarchical Classification of Alceste program.



From: Report produced by Alceste software, 2006.

Em cima: 2,166 ECU classes
Class 1 Class 4 Class 2 Class 5 Class 3 Class 6

Finally, the program held a Hierarchical Ascendant Classification (5th operational stage of Alceste), which contains the words present in the classes and their degree of association to the class. In addition to this result, Alceste provided for the purpose of analysis, the ECU that constituted each class, with their degree of association to the class. This allowed grasp the features and the sense of implicit contents in classes and also name them, as described below:

CLASS 6: Educational activities: sources and strategies/CLASS 3: HIV testing and counseling;
CLASS 5: Information on transmission and prevention of HIV/AIDS/CLASS 2: Representations of AIDS;
CLASS 4: Condoms: concepts and terms of use/CLASS 1: Talk about AIDS in everyday social relations.

The content relevant to the object of this study is presented across in all classes but it is more significant in classes 3, 6, 5 and 1, respectively, which are described below.

Class 3 is composed of eight subthemes. The content refers to the experience of use of the services by subjects during the period of pregnancy, in which they received prenatal care, in which the supply of tests occurs, including anti test -HIV; procedures and conduct of health professionals related to the conduct of examinations and obtaining their results.

Class 6 is composed of 17 subthemes, whose contents deal with: assistance activities developed in the study scenarios; professionals who participated in these activities; the different sources of information about HIV/AIDS, including those obtained in the MHC; strategies that are or could be used for dissemination of information and the development of educational activities in the MHC.

The content of class 5 are comprised in seventeen subthemes and refer to modes of transmission and prevention of HIV recognized by the study subjects, including information obtained in the MHC; perception of vulnerability, especially in health care services.

With regard to the class 1, with 11 subthemes, the content is related to people who live with the respondents in their family and social environment and circumstances in which questions relating to HIV AIDS are addressed, including HIV testing. Also content that show the difficulty of addressing issues related to gender and sexuality, particularly within the family, are present.

The content of the class 2 concerns the social representations of HIV/AIDS, constituted by the deponents, and on class 4 it is related to the use of condoms or not, associated with a temporal relationship of use.

In the last two classes, aspects related to the approach of professionals in offering test are also manifested, however, significantly less mentioned than in classes previously described.

The reading and individual and cross-sectional analysis of the discursive production of the deponents in classes highlighted aspects regarding the care of professionals in primary health care in MHC, both at the individual and collective scope, which allowed the development of two categories of analysis that are discussed in the study as follows.

Approaches in individual care in the MHC network of Rio de Janeiro

Under the individual care, we observed three modes of conduct of health professionals during the provision of HIV testing. The first depicts an approach that approximates the practice of counseling, due to some of its characteristics, in other words, it evidences procedures that involve listening, guidance, reporting on the exam routine and respect the decision.

> *[...] first he (doctor) talks, he says that it is important to know if we are healthy. And if we have some problem, we have to treat the baby as soon as possible. Then he talks a lot, then then he asks if you agree to do it; if we accept, he asks us to do it, then he indicates where we can do it, and we do it*. (Class: 3, x^2=4)

> *[...] She only talked about HIV testing. Then I asked why I had to do it, so she listened to me and explained that if we have something, we can already see, and treat the baby*. (Class 3, x^2=16)

> *When I did prenatal they (the doctors) gave information. First they ask the exams and then explain the reason for the tests. They explain that if the mother is infected with AIDS, the child may be too, so it is important to it*. (Class 3, x^2=8)

> *[...] He talked about remedies, because depending on the severity we can have a normal life, sometimes it may happen hair loss, or one can or cannot lose weight. He explained that young women needed to go with parents to do the HIV test. I did not need it, because I was nineteen, but younger girls had to come with parents to authorize it, because they performed prenatal care to girls from thirteen to nineteen there*. (Class 1, x^2=5)

This type of conduct by professionals is evidenced as infrequent, but it is observed in the statements that women could make their choice in relation to the realization of the test consciously and oriented with some information, when the procedure was adopted. On the other hand, there is no uniformity about the content covered and no presence of all components of counseling, including emphasis on informative aspects.

As defined by the National Coordination of STD/AIDS[10-11], counseling is a process of active listening, individualized, customer-oriented and requires the establishment of trust and help. It is characterized by a dialogue based on trust, which aims to provide conditions for the person to assess its own risks and make conscious and informed decisions related to STD/AIDS. It should therefore allow a differentiated educational relationship which does not exclude, but, on the other hand, it is not limited to promoting preventive guidelines. Thus, "The informational content is not lost in generalizing and impersonal speeches; rather, it is apprehended, to the extend that it is translated into reflections focused on decision-making and attitudes situated in the context of the experiences of its interlocutor".[12:122]

One must also consider that counseling does not end in the offer and consent for testing, but it is proposed to revise beliefs and conditions of vulnerability that characterizes the component of risk assessment, in addition to approaching women to health services, promoting the construction of alternative care and protection[2] taking care to respect the woman's decision based on informed educational action.

In a more recent study on pre and post-HIV test for pregnant women[13] held in Fortaleza, it was found in field observations that professionals analyzed did not perform risk/vulnerability assessment and did not oriented on preventive practices. The authors noted that these same professionals fail to provoke dialogue about the risk experienced by pregnant women.

Also in another recent study on the perception of users on counseling[14] it was observed that they perceived the informative component as the first step for the prevention and care. They also observed that after receiving the guidelines they felt more reassured and encouraged to take the test because they considered themselves more informed to take care of themselves. In another study on the evaluation of pre-test counseling in CTCs in the state of Rio de Janeiro[15], of the 117 users, in which the majority were women (54.1%), the majority declared himself very satisfied (58.1%) or satisfied (38.7%) with the service offered. In the same population, there was also high satisfaction - being satisfied (61.0%) or very satisfied (38.4%) - in relation to listen to their feelings and anxieties during the service. However, there were also cases of little satisfaction, attributed not just to the counseling theme. On this indicator, 23.8% of professionals interviewed reported not approaching this topic with users, because they believed it was not part of the advisor's role, or they only addressed those feelings when requested by users.

The second type of behavior identified, far more common than the previous, shows a practice in which arguments are placed by the professional who seem to aim to induce acceptance of the completion of the test, which is completely contrary to the concept of counseling and any other type of educational activity that stimulates reflection with a view to a conscious decision-making, and it is more consistent with the traditional model of care, with medicalized and authoritarian character.

> *He said I had to do it, because HIV can be transmitted to the child, but he gave no further guidance. I did the HIV test right here at the clinic. If I am with HIV and become pregnant, it will infect the child through the blood as pregnancy progresses, because the child's blood and mine are the same.* (Class 3, x^2=5)

> *He said it was an HIV test that I had to do for my baby's safety and also to see if I had some problem. He said it was a test that would only draw blood; I would have no problem, only if I really had the HIV virus, that there was going to start a treatment focused on what.* (Class 5, x^2=10)

> *When the doctor asked the HIV test I took a fright, but he said it was the procedure, that it did not mean I had AIDS, but I would have to take the exam, it was only a precaution.* (Class 3, x^2=25)

In this type of behavior it is verified in the interviews that the professionals use an approach that aims at inducing the acceptance of testing, directing the focus of his speech to what most worries or sensitizes women, that is their safety and the health of their unborn children, not favoring the routine questioning, with the possibility of not doing so, as a decision of the subject of care. Similar behavior has been observed in other studies such as the research with pregnant women in Salvador.[16]

Giving women opportunities to detect as early as possible HIV infection, as well as reducing vertical transmission to children constitute the goal of the Ministry of Health of Brazil, which in 2001 set recommendations for prevention of vertical transmission of HIV and antiretroviral therapy in pregnant women, and also created the Born Project with these goals.[3] However, this cannot be employed as the sole convincing strategy for pregnant women to carry out the test.

It has been observed[16-17] that the emphasis on child protection has been used to prevent women to refuse to take the test. It should be noted that even being of utmost importance to preserve the health of the child, the realization of the anti-HIV test should respect the free will of women, with the development of counseling as recommended.

The third behavior reveals arbitrary practices, either by omission of minimum information necessary to understanding the significance of the test, either by imposing stance, which gives the connotation of obligation to perform the test by the power of decision of professional.

> *In prenatal care I did not received any guidance. The doctor asked the HIV test and I did it. Doctor J.C. asked, but he did not explain anything. But I did it. It is to detect if we have AIDS.* (Class 6,x^2=22).

> *S. asked the HIV test in this pregnancy, she is a nurse. In the other pregnancy Dr. R. asked, he said, "You will have to do this HIV test,"*

> *and asked the other tests. I said: is it necessary? He said: "surely, in pregnancy you always have to do it". (Class 3, x^2=39).*
>
> *[...] I also did it in prenatal care (HIV test), because here in the clinic they force you to do it. (Class 1, x^2=14).*
>
> *[...] when I was pregnant I did the HIV test. They do it in pregnancy. They say that all pregnant women have to do the HIV test to see if she is contaminated. I did at the H. B. clinic* (Class 3, x^2=27)

These reported situations that are frequently mentioned by interviewees configure an ethical problem, since it contradicts an inalienable right that is granted to people, that they can choose to take the test or not. It is a type of conduct that has been severely questioned by many bioethicists, because it perpetuates the medical authoritarianism and in customer relationship service.[18] It is observed that this type of behavior is not uncommon, even outside of the scenarios in this study, and generates assumption that its objective is to make women believe that the test is part of routine examinations normally requested to pregnant women, as it can be seen, also, in the following statements:

> *[...] in pregnancy, it is part of prenatal care, today is mandatory everywhere for pregnant to do the HIV test, because if the baby is an HIV carrier, it can be treated, so it is normal to take a pregnancy test, it is an HIV test in pregnancy* (Class 5, x^2=36)
>
> *[...] when I was pregnant of the girl, I did here at the clinic. They indicate various exams and also ask HIV test. It is mandatory to do it when pregnant. They just gave the paper, but did not explain anything. When the result arrived, I was afraid.* (Class 3, x^2=38)

In a study with HIV-positive pregnant women for HIV[19], it was also detected that some of them were only notified about the exam, without having received any kind of guidance. Some more recent studies[13;20] also show that professionals put the test as compulsory indicating that this practice has been perpetuated in recent years. On the other hand, the lack of counseling in different health establishments, including MHCs, maternity hospitals and family health units, has also been reported in studies[7; 21] by the segment of the female population or by health professionals.

These situations depict that the conduct of health professionals are determined by their own parameters, therefore disconnected from official recommendations of State policies. This aspect is clearly evidenced in the study[18] developed with 18 health professionals in which 17 were positioned in favor of mandatory HIV testing in prenatal care, regardless of the wishes of the client, with the argument that women find it difficult to assimilate the information that is provided to them or because they have no interest in the information. By the author analysis, professionals blame the clients without realizing

that the mistake is in the way they approach issues related to HIV/AIDS and not in the capacity of understanding of women.

There is, therefore, an authoritarian and conservative practice, totally contrary to what is recommended in terms of citizenship rights. For pregnant women, official documents recommend that, minimally, guidelines on HIV/AIDS should be passed so that they can decide on the implementation of anti-HIV test, which is offered in prenatal care. Documents even emphasize that when women choose to perform it, they must authorize it through the Informed Consent Form, and must attend at least two meetings for counseling.[5;7]

Health professionals involved in the care of pregnant women have the responsibility to act according to standards established by the NP-STD/AIDS for the prevention of vertical transmission of HIV in the context of the UHS. One of the basic premises for a person to perform its HIV testing is doing it voluntary. Considering the impact that this result can bring to the person's life, this decision must be personal, so that it can ensure the human person with citizenship and respect.[10]

If the approach with clients about HIV/AIDS in the pre-test is deficient in the majority of cases, in the post-test, it is non-existent before a negative result, not enabling any possibility of resuming the issue in future visits, restricting, once again, the right of access to information, because even in this situation the provider should discuss the test results and reinforce the information about the mode of transmission and prevention measures of HIV and other STDs.[3;5]

Collective care approaches in the MHS network of Rio de Janeiro

As for counselling or guidance activities developed with collective strategies in assisting women in prenatal care, it is observed that they do not occur uniformly, in other words, they do not always integrate the actions directed by professionals to pregnant women or they address issues related to HIV/AIDS or HIV testing very superficially. When refering to these activities, the respondents make it clear that they are distinguished from those that are held in other locations of service to customers, both in relation to its purpose as also in relation to how the content on HIV/AIDS is addressed, as seen below.

> *Nobody said anything to me during prenatal care, it is only a consultation. In the lecture they spoke only about the exams we had to do, and to take the HIV test.* (Class 3, x^2=14)

> *When we schedule a consultation for the first time, we watch a talk for pregnant women on Monday, and they ask a few things, but nothing specifying the disease, it is more directly to pregnancy and to schedule a consultation.* (Class 1, x^2=1)

> *[...] It is also a health center, where the HIV test is performed. Then when we arrive to get the result they make a quick lecture and talk about how to handle, how we can prevent from being infected, it just talks about AIDS.* (Class 6, x^2=2)

In the study scenarios, lectures or meetings, as quoted, have an informative technical nature about the service routine, as the number of consultations, scheduling exams, among other procedures. When talking about the exams, health professionals mention the offer of HIV testing, pointing its optional character and sometimes emphasize its importance for the prevention of vertical transmission of HIV. The sessions in which issues related to HIV infection and its implications for the woman and the child are placed in detail are rare, allowing for reflection and a clear perception of risk for HIV infection. Thus, it is observed that the developed actions distance themselves from components that integrate counseling, in other words, emotional support, educational support and risk assessment.

A research that proposed to analyze collective counseling on a unit with the Family Health Strategy in Fortaleza[4] revealed an even worse situation than the one we reported because it was found that this type of practice is not part of the routine, being justified by the difficulty of managing time due to the other activities.

We observe, however, that in this study, when it was made reference to the realization of collective advice on other services for which they were forwarded to the test, the respondents indicated that these activities were distinguished from those that are performed in the study settings, both in relation to its purpose as also in relation to how the content on HIV/AIDS was addressed. It is worth noting that a group of interviewees reported that performed the HIV test in a Counseling and Testing Center (CTC) in the municipality of Rio de Janeiro, mentioning the collective advice in the pre and posttest.

> *This lecture was in H., in the city. I did the HIV test there. Before we do the HIV test there is the lecture. In the lecture they talk about AIDS, how to prevent, they say a lot of things about our partner.* (Class 3, x^2=4*)*

> *The doctor here asks us to do HIV test at the HESFA, then there, before we do it, there is a lecture, they join people there and give a lecture to explain, and to people not to get scared.* (Class 3, x^2=22)

It can be checked differences in the perception of the respondents regarding the contribution of information and also the approach strategy on issues related to HIV/AIDS in different services. A respondent said that from the lecture she could convince her companion to perform the test. Although it was an isolated case, it is an example of how the approach on certain issues contributes substantially to help women to face the situations posed in everyday life, including related to sexual practices with their partners.

The document that supports the practice of counseling on STD/AIDS in basic health[11] refers that the process of counseling can be developed at various times, and can be performed for groups. It highlights that it should contribute to the practice of educational actions on health and that, based on ethical prerogatives, it should reinforce and encourage the adoption of preventive measures, the orientation of individuals in relation to citizenship

and full use of their rights, extrapolating therefore the mere practice of serologic testing for HIV by routine determination of service.

It is estimated, therefore, that in the context of prenatal care, under the scenarios of the study, HIV testing is offered systematically, but not accompanied by the practice of counseling on its full form.

CONCLUSION

Undergoing an HIV test, though not for the first time, stands as a stressful situation to be faced, especially for women, because of the possibility of involvement of a being in formation in the case of pregnant women. It is a process that does not occur smoothly, even when the person consciously chooses to perform it, because it causes feelings of distress, "nervous" and "scared" that are experienced from the application of the test, and extend during the period prior to information of the result, as mentioned by several interviewees.

Thus, it transcends the detection of the presence of viruses in the organism, since the possibility of a positive result implies disclosing to the world, and to the woman herself, the representations constructed and shared in the society, especially those that represent negative elements associated with the disease and the virus. It can mean the possibility to have her identity aligned to what was socially assigned to the representation of the "other", or the "abnormal", the promiscuous, the drug users, finally, those who break the social or moral norms, as it is perceived by the users of this study. It is the potential danger of seeing unveiled their desires or practices repressed and denied, or also the possibility of a disappointment given the fact that a rule or covenant of conjugal or loving relationship was broken.

Thus, emotions, anxieties and other feelings that may manifest on the uncertainty of the test result may be the same experienced by any individual against other situations imposed by life, however, this situation tends to have a higher intensity due to the subjective interpretation of the individual, such as beliefs, values and ideas, shared socially in relation to the epidemic.

Therefore, the complexity of this moment to the individuals involved is evaluated and monitoring by professionals to provide support and guidance to face these situations is crucial in this process. Although some stand the hypothesis that induction, coercion or imposition for the test are imbued with the "best intentions", it is considered that professionals should have the sensitivity to support the customer, regardless of any rule or recommendation that point to such a need.

The process for the diagnosis of HIV, as recommended and when properly conducted by professionals presupposes viable reflection of the individual with its own history and creating a space that allows them, especially women, to take ownership of the aspects that may increase their vulnerability to HIV infection, by recognizing and reframing of behaviors

and attitudes considered safe. It is here that professionals can initiate a discussion with their clients about the meaning of the test for their lives and the possible consequences from the result, establishing a dialogic educational practice. The realization of anti-HIV test does not only have the goal of detecting the causative agent of AIDS, but also offer a favorable field to promote prevention.

We conclude that the standard that defined the conduct of professionals in the situation analyzed was free will, in other words, it was determined from the values of professionals, their beliefs and conceptions or representations, including in relation to their own clientele. Thus, the results of this study point to a practice that distorts from what is being advocated in State policy and by the Official programs in relation to the practice of counseling in the offer of HIV testing, but also point to the existence of values and representations referred to customers of MHC as being less able to stand before health options sometimes difficult.

Finally, it is considered worrisome that, after more than a decade of its implementation, counseling has been neglected in many services, both by the lack of it or by the inadequacy or incompleteness of its procedures as evidenced in this study. This must be translated in urgent need of measures to correct the distortions not to harm this practice of such magnitude in the prevention and control of epidemic.

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