

# MANAGERS' DISCOURSE ON BARRIERS TO ACCESS HIV RAPID TEST IN PRIMARY CARE

## DISCURSO DE GERENTES SOBRE BARREIRAS DE ACESSO AO TESTE RÁPIDO ANTI-HIV NA ATENÇÃO PRIMÁRIA

## DISCURSO DE LOS GERENTES SOBRE LAS BARRERAS AL ACCESO A LAS PRUEBAS RÁPIDAS DE VIH EN ATENCIÓN PRIMARIA

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Objective: to analyze the barriers to access HIV rapid test from the perspective of the discourse of managers of Primary Health Care services. Method: exploratory, qualitative research conducted in a health district of João Pessoa, Paraíba, Brazil. Data collection was performed in September 2017 with 13 health managers. The empirical material was based on the theoretical-methodological contribution of the Discourse Analysis of the French matrix. Results: the discursive block "Barriers of user access in the health system to perform the HIV rapid test in Primary Health Care" was identified. The discourses revealed barriers of access tied to the dimensions: geographical accessibility, availability, feasibility and acceptability. Final considerations: the units have the potential to strengthen the performance of the HIV rapid test, however, they need political support aimed at strategies to strengthen the performance of the rapid test with scope to reduce access barriers.

Descriptors: HIV. Early Diagnosis. Primary Health Care. Access to Health Services. Qualitative Research.

*Objetivo: analisar as barreiras de acesso ao teste rápido anti-HIV na perspectiva do discurso de gerentes dos serviços de Atenção Primária à Saúde. Método: pesquisa exploratória, qualitativa, realizada em um distrito sanitário de João Pessoa, Paraíba, Brasil. A coleta de dados foi realizada em setembro de 2017 com 13 gerentes de saúde. O material empírico foi fundamentado no aporte teórico-metodológico da Análise do Discurso de matriz francesa. Resultados: identificou-se o bloco discursivo "Barreiras de acesso do usuário no sistema de saúde para realização do teste*

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*rápido anti-HIV na Atenção Primária à Saúde". Os discursos revelaram barreiras de acesso atreladas às dimensões: acessibilidade geográfica, disponibilidade, viabilidade e aceitabilidade. Considerações finais: as unidades possuem potencial para fortalecer a realização do teste rápido anti-HIV, entretanto, necessitam de apoio político que visem estratégias para fortalecer a realização do teste rápido com escopo na redução das barreiras de acesso.*

*Descritores: HIV. Diagnóstico Precoce. Atenção Primária à Saúde. Acesso aos Serviços de Saúde. Pesquisa Qualitativa.*

*Objetivo: analizar los obstáculos al acceso a las pruebas rápidas del VIH desde la perspectiva del discurso de los gerentes de los servicios de Atención Primaria de Salud. Método: investigación exploratoria y cualitativa llevada a cabo en un distrito de salud de João Pessoa, Paraíba, Brasil. La recopilación de datos se realizó en septiembre de 2017 con 13 gerentes de salud. El material empírico se basó en la contribución teórico-metodológica del Análisis del Discurso de la matriz francesa. Resultados: se identificó el bloque discursivo "Barreras de acceso de los usuarios en el sistema de salud para realizar la prueba rápida del VIH en Atención Primaria de Salud". Los discursos revelaron barreras de acceso vinculadas a las dimensiones: accesibilidad geográfica, disponibilidad, viabilidad y aceptabilidad. Consideraciones finales: las unidades tienen el potencial de fortalecer el desempeño de la prueba rápida del VIH, sin embargo, necesitan apoyo político dirigido a estrategias para fortalecer el desempeño de la prueba rápida con margen para reducir las barreras de acceso.*

*Descriptor: VIH. Diagnóstico Precoz. Atención Primaria de Salud. Acceso a los Servicios de Salud. Investigación Cualitativa.*

## Introduction

The incidence of Human Immunodeficiency Virus (HIV) stands out as a public health problem in Brazil and worldwide due to its pandemic characteristic and its enormous potential to cause death, despite being preventable and treatable. The rise of coping actions is notorious, however, not all users have equitable access, signaling several barriers to access the health service<sup>(1)</sup>.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), in 2018, there were 37.9 million people living with HIV (PVHIV) worldwide. Of these, about 8.1 million were unaware of their serological condition<sup>(2)</sup>. In Brazil, from 2007 to June 2019, 300,496 cases of HIV were recorded. In the state of Paraíba, between 2017 and 2018, 1,282 new cases of HIV were diagnosed and up to October 2019, 470 new cases were diagnosed<sup>(3)</sup>.

Dating back to the onset of the virus, the Brazilian government has been implementing actions and services aiming to reduce the incidence rate of infection and avoiding the possibilities of transmission, including the performance of the anti-HIV Rapid Test (RT). This organizational device has been highlighting itself as an important strategy in the identification of positive cases, assisting in early diagnosis, in

order to be used as a device with global reference in the assistance to users<sup>(4)</sup>.

The Ministry of Health, through Ordinance n. 29 of December 17, 2013, decided to expand the provision of this diagnostic technology for Primary Health Care (PHC) services, directly favoring the process of availability of RT for early serological identification, treatment initiation and interruption of the epidemiological chain<sup>(5)</sup>.

The execution of anti-HIV RT, in the context of PHC, has been seen as an immediate response to the demand for HIV cases, because, in addition to favoring the expansion of access and the formation of the bond between professional and user, provides the organized flow of the care network at the primary level, recommended as the main gateway to the Unified Health System (UHS) and the ordering axis. This insertion of the diagnostic offer expressed a new face of health policies to consolidate the decentralized model<sup>(6)</sup>.

Thus, it is essential to analyze the barriers of access to anti-HIV RT in PHC to better understand the use of health services and their limitations, since these units should provide embracement, diagnosis, early treatment, in addition to an offer that contemplates the principles of universality and accessibility. Such prerogatives indicate

the need for adequate provision of tests for the units, expansion of the offer of the examination and expansion of training for family health team professionals to perform the procedure correctly<sup>(7)</sup>.

After searching national and international databases, it was possible to investigate studies that indicate that PHC professionals recognize the importance of anti-HIV RT as a care strategy, although it is often not performed as recommended, due to structural and operational factors<sup>(8-9)</sup>. However, when concerning studies that address the organizational aspect of the difficulties that permeate access to anti-HIV RT in PHC, there were no studies addressing the access barriers indicated in the discourse of health managers, which impairs the understanding of comprehensive care and decision-making in the fight against this infection.

In view of the potential of the execution of the anti-HIV RT as a strategy for prevention and health promotion, it is evident the need to carry out studies that analyze the theme and, specifically, the barriers of access the RT in PHC, signaling the limitations and challenges inserted in this context, with emphasis on the perspective of health managers, important actors for the implementation and operationalization of access to RT in practice, since the process involves from the purchase to the availability of RT in PHC services<sup>(10)</sup>.

This analysis allows supporting discussions with a view to possible interventions and adaptations that improve access to anti-HIV RT within PHC, demonstrating the relevance of this investigation. Regarding the theme, the present study is based on the following guiding question: What do the discourses of PHC health managers reveal about barriers to access HIV RT?

Thus, this study aimed to analyze the barriers of access to HIV RT from the perspective of the discourse of managers of PHC services.

## Method

This is an exploratory research of qualitative nature, guided by the criteria included in the checklist of the Consolidated Criteria for Reporting Qualitative Research (COREQ), based

on the theoretical-methodological contribution of Discourse Analysis (DA) of Pecheutian French matrix, which epistemologically is linked to linguistics, psychoanalysis and historical materialism<sup>(11)</sup>.

DA proposes to analyze language as a social practice, through an unconscious subject, without issuing judgment to language, as right or wrong, but to expose what it is and how it works, being interested in how speech will be allowed. Considering that the practices of thought are evidenced through the discourses, the French DA is responsible for explaining the process of language construction, since there is no discourse without subject or subject without ideology<sup>(11)</sup>.

The study was carried out in the PHC services of a Health District in the eastern region of João Pessoa, capital of Paraíba. The place chosen to integrate the research scenario was selected because it presented the highest number of health units and users who access the HIV RT. The participants were intentionally selected, considering as inclusion criteria to have a minimum performance of six months as a manager in the local health system.

The Health District surveyed has 18 health managers, however, after contact with the participants, 13 were included in the study because they were in compliance with the established criteria. The Health Manager Program in force in the municipality is supported by a rule established by the Ministry of Health (MH) and the World Health Organization (WHO), included in the National Primary Care Policy (NCP), receiving reference character for all Brazilian municipalities, has a position of management and monitoring of the Family Health Strategy (FHS) of the selected municipality.

Data collection occurred in September 2017, through an interview technique with the contribution of a semi-structured guide, organized according to the research objective, with open questions about the organization of PHC services regarding access to HIV RT. The interviews were previously scheduled, according to the availability of the participant, and were

conducted in a private environment chosen by each professional, individually, after signing the Informed Consent Form (ICF). The recordings were made with the aid of a smartphone, lasting an average of 20 minutes. Subsequently, the interviews were transcribed in a field diary, which favored the organization of the research corpus. In order to preserve anonymity, the collaborating subjects were identified by the letter M, representing "manager", followed by Arabic numerals (M1 to M13).

Considering that the conception of DA French line seeks to express the historical character, focused on centrality in discourse and the enhancement of historical observation based on divergent perspectives, and not on the search for true meaning, the analytical device follows two distinct and complementary moments: the analysis itself and the writing of the analysis<sup>(11)</sup>.

The first stage, the analysis itself, proceeds to the circumscription of the concept-analysis, whose analysis scope is the saturation established by the absence of new elements in the discourse, until being closed. Thus, the discursive corpus was defined by floating reading, after analytical reading, whose function is to assist the analyst to understand the meanings related to the answer of three heuristic questions: What is the concept-analysis present in the text? How does the text construct concept-analysis? To which discourse does the concept-analysis constructed in the way that the text constructs belongs<sup>(11)</sup>?

Subsequently, exhaustive readings were performed to allow the recognition of the senses and textual marks until achieving the saturation of the senses.

Next, the meaning edified by the discourse of health managers was sought in reference to the object of study, emphasizing the functioning

of ideology in textualization<sup>(11)</sup>. The concept-analysis established in this study was "Barriers of access to HIV RT". This concept is based on the textual marks denoted in the discursive corpus elaborated through the discourses of the management subjects.

The second stage, the writing of the analysis, involved the characterization of the analysis through contextualization and elucidation of the theme, and the explanation of the theoretical-analytical device<sup>(11)</sup>. Thus, the following discursive block emerged: User's barriers to access the health system to perform the HIV RT in PHC. For analytical categorization, the dimensions of access were used: geographic accessibility, availability, feasibility and acceptability<sup>(12-13)</sup>.

The ethical and legal principles established in Resolution n. 466/2012 of the National Health Council were respected, concerning the research involving human beings. The research project was approved by the Research Ethics Committee (REC) of the Nursing and Medicine Schools of Nova Esperança, under Opinion n. 109/2017 and CAAE 72757817.6.0000.5179.

## Results

Chart 1 includes a corpus constructed through the dimensions and the respective barriers to access HIV RT in PHC with the discursive fragments of 13 health managers with work time of over six months in PHC, among which 4 are social workers, 4 physical therapists, 2 physical education professionals, 2 speech therapists and 1 administrator. Of this number, only one was male and the other, female. Thus, these discourses will lead the discussion of the established analysis concept.

**Chart 1** – Discourse of health managers related to dimensions and their corresponding barriers that distance service users to perform HIV RT in PHC. João Pessoa, Paraíba, Brazil - 2017

<b>Dimension</b>	<b>Barriers</b>	<b>Discursive fragments</b>
Geographic Accessibility	Inadequate infrastructure	[...] <i>this unit is small for the community that we meet [...]</i> . (M10).
Geographic Accessibility	Service location away from users	[...] <i>while isolated [far from the users' homes] no, when there is rapid test we always make a swap [...]</i> . (M4).
	Vulnerable local security	[...] <i>we meet three uncovered areas, only extremely risky areas, areas of total vulnerability, both in poverty and in the use of drugs [...]</i> . (M10).
Availability	Weakened articulation between the points of attention	<i>Here we have no [HIV RT], if there were we would refer</i> (M6). [...] <i>he was referred to the Clementino [reference hospital], where he does all this psychological part, the cocktail part is all sent there [...] he does the test, if positive, we send him straight there [...]</i> . (M11). <i>As there is no [HIV RT] here, if the user has any symptoms, we refer him Clementino [Reference hospital] [...]</i> . (M12).
	Centralized opening hours	[...] <i>we inform and the user will already know that, on that day there will be an action, when, there will be the offer of HIV rapid test [...]</i> . (M8).
	Lack of familiarity with professional training	<i>The difficulty for the user is because we do not have the professionals with this course [...]</i> . (M1). [...] <i>the biggest difficulty is that we do not have any professional trained to perform these tests [...]</i> . (M7).
	Scarcity of insum	[...] <i>occasionally it ends and it takes time to arrive, the transfer is slow to happen [...] that is, lack of supply [...]</i> . (M2). <i>We sometimes lack the rapid test, right now there is none [...]</i> . (M5).
Feasibility	Generation of avoidable costs	[...] <i>they have to move to a place [Reference hospital] that needs, for example: financial resources, transportation, this whole issue.</i> (M3).
Acceptability	Discrimination against PLHIV	[...] <i>but I believe that this type of user is for Clementino [Reference Hospital] for treatment [...]</i> . (M13).
	Stigmatization	[...] <i>now when you get here in the night action and we say we have a rapid test, what is it? AIDS? Most do not want to do it, it seems they are even afraid to know if they have it [...]</i> . (M9).

Source: Created by the authors.

## Discussion

The DA French-line was used as a theoretical-methodological device to elucidate the construction course through language and to interpret the corpus of this study based on the concept-analysis “access barriers to execute of the HIV RT”, which meets the actions of thought found in the discourses of health managers, from the perspective of the object of this study, revealing the conduct of ideology in textualization<sup>(11)</sup>.

Analyzing the discursive fragments and textual marks, there were situations that indicate barriers to perform the test related to the dimensions geographical accessibility, availability, feasibility and acceptability, respectively, which will lead the discussion of the concept-analysis established. In the discourses, circumstances were revealed that weaken access and provide barriers that distance users from the test.

The discourses of health managers refer to the geographical accessibility dimension, linked to access to the health service, and are related to

the adequacy of the location of the services in reference to users' location<sup>(12-13)</sup>.

The barriers revealed in the discourse tied to the "geographical accessibility dimension" were: inadequate infrastructure, location of the service far from users and vulnerable local security. The size of the physical structure is seen as a limitation to the access of the RT, since to better assist the community demand in the space would require a larger service unit.

A study on HIV test in PHC identified differences in the quality of care and access to RT between two units with dissimilar physical structures. The literature indicates that a smaller space negatively influences the proper care in the execution of the test, while the one with more space enhances the support, by providing spaces for testing, privacy and environment for strategic meetings and embracement<sup>(14)</sup>.

Another study conducted in a municipality of Bahia identified that the reserved and private space is something desired by the user to perform the test. The adequate physical structure in PHC units positively influences the practices of health professionals, favoring interventions with technical quality and more humanized working conditions<sup>(15)</sup>.

Another barrier identified was the location of the service far from the users, mentioned in the segmentations of M4, which rescues in its discourse the distance from the users' homes to reach the unit, in addition to the displacement of their homes to the referenced unit, as the location do not offering the RT. The speech of this manager characterizes an important obstacle in the access to the HIV RT, because it allows the user to mismatch with the referenced service, and the professionals of the unit destined to have other demands, neglecting the performance of the test.

Thus, the distance between the geographical location of health services and the user's residence must be overcome, so that there is no pilgrimage of patients and mismatch with the service between different places and municipalities to access the RT<sup>(16)</sup>.

Finally, the geographical accessibility dimension, M10 mentions the risks related to security around the unit, configuring itself as a barrier of access to the HIV RT. In addition, it mentions social vulnerability, including drug use, weakening the service, and providing the user to choose not to go to the PHC unit to perform RT due to local insecurity.

A study highlights the importance of PHC safety in offering safe and quality care; for this, it is necessary to articulate responsibilities related to management, professionals, physical structure and security around the health service<sup>(17)</sup>, so that the patient finds in the unit the tranquility and feeling of security necessary to feel embraced in that environment.

"Availability" is another dimension that emerged in the discourses, being tied with the weakened articulation between points of attention, centralized opening hours, lack of familiarity with professional training and scarcity of education. This situation allows reflecting in the offer of health actions in the right place at the right time, in order to assist the real needs of the population, the capacity of the service to assist users, in addition to aspects regarding the appointment, comprehensiveness of care, quality and longitudinality of care<sup>(12-13)</sup>.

The discursive fragments of the statements of M6, M11 and M12 reveal meanings that indicate barriers to the performance of HIV RT in PHC services, through textual marks such as "forward and reference". This discourse is justified as discursive memory in allusion to the biomedical and hospital-centered ideology materialized by the social memory established in historicity, because they signaled meanings that seek curative and specialized care in their interdiscourse, directing them to the Testing and Counseling Centers (TCC) that operate in the Clementino Fraga Hospital Complex, without considering that the TCC should have a character complementary to care<sup>(18)</sup>.

A study carried out in the South of the country addresses the need to refer the user to the TCC as a point for the construction of joint prevention strategies, favoring the flow of care

in the care network in an organized, orderly and counter-referenced manner, which aims to eradicate risk behaviors, which can be dispensed to complement comprehensive care in different health services<sup>(8)</sup>.

The meanings attributed in the Discourse of M8 refers to the historicity of the care represented by the campaign model as health actions are punctual interventions, without offering alternative hours of care according to the patient's need, implying impasses in the individual's compliance seeking the RT.

A research developed in PHC in the South of the country identified that the scheduling model is an important tool to optimize the quality of access to RT in PHC, which enables care on specific days for spontaneous demand and preserves the other days for routine continuity and health promotion, in order to absorb part of the population that does not adapt to the scheduled care<sup>(19)</sup>.

Therefore, some studies attribute some questions about spontaneous demand in relation to the limited demand, in which the user tends to seek technical assistance services already in the process of illness with a curative character, in contrast to that recommended by the Ministry of Health, which aims at prevention and health promotion<sup>(20)</sup>.

The statements of M1 and M7 highlighted the need for qualified professionals. A study points out that it is multiprofessional competence to perform the HIV RT; the MH requires only the graduation and training to perform the test, highlighting the importance of involvement in the process of all categories, whose action enhances the implementation of RT in PHC<sup>(9)</sup>.

A study developed in the Northeast of the country emphasizes the need to train all professionals who participate in the team, in order to promote the strengthening of interaction and cooperation between the team in the sharing of knowledge in the execution of the RT<sup>(18)</sup>.

The current policy of coping with HIV estimates that the services offered by PHC are problem-solving and accessible, because the execution of RT leads to the entry of users into

the service, optimizing the health offer<sup>(16)</sup>, which reinforces the need for PHC professionals, as social actors, to qualify to perform the HIV RT.

In order to close the barriers of access tied to the availability dimension, the discourses of M2 and M5 mention textual marks referring to the "lack of supply", the scarcity of supply and the delay of replacement as a greater deficit of fragility for the performance of RT. The scarcity of this device distances users from the test, weakening their access to the test. To enhance the test in PHC, there is need to provide delivery logistics and availability of the supply, that is, the HIV RT kit in the health service<sup>(18)</sup>.

Based on the discursive sequence, the dimension "Viability" has as a barrier of access to the generation of avoidable costs, present in the speech fragment of M3, which alludes to the degree of adequacy between the cost of using health services and the ability to pay individuals<sup>(12-13)</sup>.

This barrier transmits the difficulty of the user to move to specialized services, since the responsibility of the diagnosis was transferred from the first instance, PHC, to tertiary care. The professionals' statements reveal that they perceive the distance from the house to the hospital reference service as a difficulty, because users need to spend on transportation in order to access the RT.

It is worth noting that this barrier is a finding of our study and there are limitations of publications that analyze this component, with only one study found in the modality of walking as the main form of accessibility to FHS services<sup>(21)</sup>.

The last dimension of this research is "acceptability", which can be understood as the actions of health professionals from the perspective of the characteristics of users mutually, being related to the reciprocity of the professional-user and user-health system<sup>(1,12)</sup>.

The barriers identified in this dimension refer to the discrimination of people living with HIV and stigmatization. Following the line of interpretation of the senses was evidenced in the textual mark of M13 "this type of user" in apology to discrimination for assigning a label

to the user. Moreover, this discourse materializes the social recall instituted in attitudes that have a negative focus on PLHIV.

Discrimination is an ideological and practical result of the stigma constructed by society, resulting in social injustices, whether due to omission or lack of action, based on attitudes with scope in stereotypes, on the premise of bringing disadvantages to people labeled for being infected with HIV<sup>(22)</sup>.

In a study conducted in South Africa, professionals, in their work scope, still link HIV to social injury and find a way to distance from the user based on testing and medicalization, not being familiar with the holistic embracement of this individual<sup>(23)</sup>.

In another study also in South Africa, adolescent users reported discriminatory experiences, such as exclusion, treatment, precarious health care among health professionals and the other people. Moreover, the study points out that discrimination drives higher risk behaviors, distances users from test, initiation and medication treatment, weakening the user's bond with the service<sup>(24)</sup>.

Finally, the last barrier of access to HIV RT mentions the social stigma, in which M9 seeks in discursive memory the renewal of the historicity of stigma through the materialization of a pre-established social memory, perpetuated over time, in which the individual had to live with various pejorative names and adjectives<sup>(22)</sup>.

The detection of HIV brings with it a condemnation and exclusion adopted by society through stigmatization, whose materialization corroborates the tensions in the executing the RT. Therefore, even in view of the expansion of the RT offer, the test in the PHC is seen as an element that constrains the possibility of the diagnosis putting the user on display of his serological condition in the family and community environment<sup>(4)</sup>.

In southern Brazil, a study with similar discourse was developed, in which one of the participants mentioned that she felt inhibited and embarrassed when the professionals talked about the offer of RT. Thus, the performance of the HIV detection test is permeated by other demands,

related to privacy and confidentiality, besides relating the detection of HIV to moral aspects that favor the process of stigmatization in society<sup>(25)</sup>.

HIV stigma and discrimination are characterized as important barriers to access the service from the perspective of prevention, treatment and actions throughout the health scenario. Holistic support to face this infection with the adoption of social policies to cope with inequalities is paramount, in addition to the empowerment of people affected by the virus.

Therefore, the performance of the HIV RT, at the PHC level, does not converge with the accessibility of the user to the test, in proportion that there is the distancing present in the discourses of health managers in relation to that recommended by the UHS guidelines. In this conception, the discourse that support the senses for performing the HIV RT test in PHC services is predominated by the hegemonic discourse, with biomedical and hospital-centered peculiarity, referring users to specialized hospital services, in addition to the existing barriers mentioned in their statements to obtain the diagnosis.

Through the discourses of the subjects of this research, important discussions can emerge related to the adequacy of the location of the services in relation to the users' residence, the integral care, the quality and quantity of health care, the aspects related to transportation, in addition to the perception and attitudes of health professionals regarding the personal characteristics of users. Thus, these findings have an important contribution to the area of public health in general, with a view to broadening the understanding of the problem, pointing out meanings that optimize the implementation of public policies and help in decision-making focused on the integrality of access the HIV RT in PHC.

The accomplishment of the study restricted to the health manager can be pointed out as a possible limitation of the research, considering that the inclusion of other professionals who exercise direct activity with the provision of HIV RT could have contributed to a better perception of the evaluated context. Analyzing the discourse of these participants is strategic,



because it allows assimilating the context of the barriers related to the detection of HIV in PHC, since these professionals perform administrative activities with competence to eliminate these barriers, from the perspective of qualification of human resources and in the restructuring of the health service.

### Final considerations

The effectiveness of HIV-positive RT in PHC still represents a problem for health management. The discourses reveal the distancing from the implementation of health policies and political commitment, intertwined in the barriers listed, taking these obstacles as fundamental in the provision of the HIV-positive RT, which is revealed by problems regarding inadequate infrastructure, location of the service far from the users, vulnerable local security, fragile articulation between points of attention, centralized opening hours, lack of familiarity with professional training, scarcity of education, generation of avoidable costs, discrimination of people living with HIV and stigmatization. This situation requires the conception and application of public policies in order to help the management of HIV care and reverse the current situation of infection in the country.

The discourses allowed identifying: the need for training/permanent education strategies for health professionals to safely perform the rapid test, without having to refer to another service or request the service from other units; the responsibility for meeting the demand, without the transfer to the reference service; the provision of supply with continuous flow of availability in the units; the organization to meet spontaneous demand; intersectoriality to promote security in access, in addition to government aid to the socially vulnerable population.

The material analyzed allowed recognizing information that will serve as subsidies for proposals for new goals and strategies to enhance the execution of RT, as well as its use for the production of new studies that understand the perspective of health managers, in addition to other professionals and users.

### Collaborations:

1 – conception, design, analysis and interpretation of data: Haline Costa dos Santos Guedes, José Nildo de Barros Silva Júnior, Amanda Haissa Barros Henriques and Anne Jaquelyne Roque Barrêto;

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