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Staff's perceptions of the implementation of protocol for maternal-child care in HIV

Percepções da equipe acerca da implantação de protocolo de atenção materno infantil em HIV

Percepciones del equipo sobre la implementación de un protocolo para el cuidado materno-infantil del VIH

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Abstract: Objective: to understand the health staff's perceptions of the protocol of maternal-child care implanted in a teaching service of regional reference for HIV. **Method:** descriptive study with a qualitative approach, carried out in 2017, in the countryside of Minas Gerais, Brazil, with the participation of 10 staff members at the teaching service. The focus group was used for data collection, and the information collected was analyzed using inductive thematic analysis. **Results:** the reports were organized in themes that portray aspects of changes performed in the service, contributions of the protocol to the organization of work processes and the integrality of the maternal-child clientele, in addition to highlighting factors intertwined in deployment that acted as facilitating or hindering factors in this process. **Conclusion:** the staff's perceptions pointed to the recognition of the potential of the protocol deployed for the care with women and children in the scenario of HIV.
Descriptors: Protocols; HIV Seropositivity; Women's Health; Child Health; Maternal-Child Nursing

Resumo: Objetivo: conhecer as percepções da equipe de saúde sobre o protocolo de atenção materno infantil implantado em um serviço escola de referência regional para HIV. **Método:** estudo descritivo com abordagem qualitativa, realizado em 2017, no interior de Minas Gerais, Brasil, com a participação dos 10 membros da equipe do serviço escola. O grupo focal foi utilizado para a coleta de dados, e as informações coletadas foram analisadas mediante análise temática indutiva. **Resultados:** os relatos foram organizados em temas que retratam aspectos das

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mudanças realizadas no serviço, contribuições do protocolo para a organização dos processos de trabalho e a integralidade da atenção a clientela materno infantil, bem como destacam fatores imbricados na implantação que agiram como facilitadores ou dificultadores deste processo. **Conclusão:** as percepções da equipe apontaram para o reconhecimento das potencialidades do protocolo implantado para o cuidado à mulher e à criança, no cenário do HIV.
Descritores: Protocolos; Soropositividade para HIV; Saúde da mulher; Saúde da criança; Enfermagem materno-infantil

Resumen: **Objetivo:** conocer las percepciones del equipo de salud sobre el protocolo de atención materno-infantil implantado en un servicio escuela de referencia regional para el VIH. **Método:** se realizó un estudio descriptivo con abordaje cualitativo, realizado en 2017, en el interior de Minas Gerais, Brasil, con la participación de 10 miembros del equipo de servicio escuela. El grupo de enfoque fue utilizado para la recolección de datos, y la información recogida fue analizada utilizando análisis temático inductivo. **Resultados:** los informes fueron organizados en temas que retratan aspectos de cambios realizados en el servicio, las contribuciones del protocolo para la organización de los procesos de trabajo y la integralidad de la clientela materno-infantil, así como destacan los factores interrelacionados en la implementación que actuaron como facilitadores o dificultadores en este proceso. **Conclusión:** la percepción del equipo señaló el reconocimiento del potencial del protocolo implementado para la atención a mujeres y niños, en el escenario del VIH.
Descriptores: Protocolos; Seropositividad para VIH; Salud de la Mujer; Salud del Niño; Enfermería Maternoinfantil

Introduction

The infection caused by the human immunodeficiency virus (HIV), considered a pandemic,[1] is still a reality experienced[2] by many women. According to the HIV and Aids Epidemiological Bulletin of the Brazilian Ministry of Health,[3] in the period from 2007 to June 2019, there were 93,220 cases detected in women, which corresponds to 31.0% of the notifications on Sinan. Among the forms of transmission is the HIV-seropositive mother to the fetus, known as vertical transmission (VT).[1] In Brazil, over the years, strategies for preventing HIV vertical transmission from mother to child have been proposed and adopted.[4]

The practice of health professionals for preventing VT should be based on updated scientific evidence.[1] Considering that, in pregnancy, the late diagnosis of HIV may result in difficulties for prophylaxis, actions towards early diagnosis should be performed, such as active search for pregnant women and guarantee of access to anti-HIV tests in the first trimester of pregnancy.[2] The detectable or unknown viral load at the time of childbirth can also associate

with the increased risk of transmission.[5] Thus, the early identification of HIV seropositivity is an important measure for preventing VT.[1]

After the birth, there is a continuity of care for prophylaxis of HIV transmission, such as non-breastfeeding, medication for the child and the follow-up of child health.[6] In addition to these specific types of care, professionals at health services need to pay attention to the reality experienced by HIV-positive women,[7] seeking to identify their experiences, behaviors, feelings, as well as their support network. A safe and quality assistance must be guaranteed[1], with an individualized, humanized, integral and problem-solving care.[7]

In this sense, health professionals' care must be continued, with actions of reproductive planning, follow-up during the pregnancy-puerperium period, and care directed to the health of women and children. The individual and social vulnerabilities should be considered in interventions of reproductive planning.[8] Concerning the conception, the guidelines on strategies to be adopted to reduce vertical transmission of HIV should be continuous, occurring since the reproductive period of planning and pervading prenatal, delivery and postnatal care.[8] The Clinical Protocol and Therapeutic Guidelines for Prevention of Vertical Transmission of HIV, Syphilis and Hepatitis Viral Infections[8] identify and discuss strategies for reproductive planning in the conception, in the HIV scenario of HIV. Thus, depending on the situation of the sexual partnerships (serum-different or serum-equal), it is important that the health team considers the possibility of using some strategies of conception, such as the programed vaginal self-insemination in case of a HIV-positive woman and a HIV-negative man.[8]

Thus, in the HIV scenario, one should consider multiple determinants of the health-disease process interwoven in the attention to the maternal-child clientele in services. Therefore, there emerge the potentialities of using protocols, since they can encourage standardized and timely care, based on the patients' needs.[9]

The protocol can work as a tool for expanding the care with the user,[10] which indicates the importance of its proper use.[5] For patients living with HIV, for example, a protocol for nutritional management was proposed in a study developed in Chile.[9] The literature indicates that the deployment of a protocol in the health service can contribute to the attention to the person with HIV.[11] In the health care with HIV-positive women, for example, the standardization was envisioned by the health team as a possibility of strengthening the service offered, seeking an integral and problem-solving care to this audience.[11]

Despite the benefits, the deployment of protocols in health services can present barriers, requiring the construction of implementation strategies.[10] It is understood, therefore, that this process in health services should be known and valued, seeking the survey of perceptions of the health team and the identification of possible obstacles. The understanding is that the team plays a fundamental role in the process of construction and deployment of the protocol, since they know the characteristics and needs of the clientele, the routine of the service and the possible strategies to suit the procedures in accordance with available resources and infrastructure.

Undoubtedly, there is need for evaluating the current protocol for its improvement, and should seek the involvement of the whole health staff.[9] Thus, the present study was guided by the research question: what is the perception of the healthcare team about the protocol of maternal-child care implanted in the teaching health service of regional reference for HIV? Therefore, the objective of this study was to investigate the health staff's perceptions of the protocol of maternal-child care implanted in a teaching service of regional reference for HIV.

Method

Descriptive study with a qualitative approach developed in the year 2017, in a teaching service of regional reference for HIV in the countryside of Minas Gerais, Brazil. Its development

occurred one month after the elaboration and implementation of the Protocol of Maternal-Child Care, constructed through the action-research.

This tool was developed as follows: initially, the researchers conducted searches on Brazilian government documents about the maternal-child care in the scenario of HIV. Subsequently, there were meetings with the health team of the teaching service for survey of behaviors and mediation of discussions on the possible adjustments. The maternal-child protocol developed addresses the following topics: Reproductive Planning, Pre-conception Care, Care with the Pregnant Woman and the Mother, Newborn Care, Child Care up to 2 years of age. After the elaboration, it was implemented in the service. Thus, the protocol was based on government documents about the subject and built jointly with the team, considering the particularities of the teaching service of regional reference for HIV.

The staff at the teaching service was composed of 10 members and all agreed to participate in the research. These members were two nurses, one nursing technician, one infectologist, one nutritionist, one pharmacist and four academic interns (three from the nursing course and one from the nutrition course). The selection criterion was: being a member of the healthcare team that worked directly with the maternal-child population.

Data collection used the focus group, a qualitative method that contributes to the processes of communication between members of the group.[10] The focus group technique works as a space fruitful for stimulating problematizing debates, critical reflection and exchange of experiences.[12]

The meeting of the focus group occurred in a room of the teaching service, with chairs arranged as a wheel, on day and time agreed with all the staff members. Thus, the participants of the focus group were 12 people, of whom 10 were staff members of teaching service and two were researchers. Of the researchers, one played the role of moderator and the other, of observer.

The moderator and observer embraced the staff members. The moderator explained the objective of the focus group and the ethical procedures, with reading, distribution and response to questions from participants regarding the Informed Consent Form (ICF). The observer received a copy of the Informed Consent Form signed by the participants. Then, the moderator initiated the focus group with the following guiding question *"How has been the process of implementation of the protocol of maternal-child care in the teaching service?"*. Therefore, the moderator conducted the focus group discussions.

The meeting of the focus group lasted 50 minutes, and the audio was recorded and subsequently transcribed and analyzed by the researchers. The analysis of the participants' reports occurred through inductive thematic analysis, which consists of encoding process guided by its own data collected.[13] For the analysis, the content of the meeting of the focus group was transcribed and organized into a file. Then, two researchers conducted exhaustive reading of this material for familiarization. Subsequently, the process of encoding began, with emphasis of words, phrases and/or sentences. In this process, the initial three themes emerged, which, after careful analysis, were regrouped into two themes.

The study complied with the ethical precepts contained in the resolution of the National Health Council n. 466 of 2012. In order to maintain participants' secrecy and non-identification, they were referred to as P1, P2, P3, ..., P10. The project was approved by the Research Ethics Committee at the Higher Education Foundation of Passos - FESP/MG, with opinion number 1.838.145, on November 21, 2016.

Results

The participants' speeches were organized in the following themes: The protocol as a tool for strengthening the care with the maternal-child clientele in the HIV context;

Deployment of the protocol in the teaching service of regional reference for HIV: facilities and difficulties, which are presented below:

The protocol as a tool for strengthening the care with the maternal-child clientele in the HIV context

The health staff's perception of the protocol drawn up was positive, recognizing the potential of this tool for organizing work processes and meeting the demands of users who are living with HIV in the teaching health service:

> *We needed such protocol, to direct the staff on how to deal with this clientele in the service, and offer a backup for us, from the staff, and for the mother and child.* (P8)

> *I think that, in case a couple gets here, and the woman wants to become mother, we will be able to handle the situation and help.* (P7)

> *We have a case in the service we will be able to solve with the protocol, it will help the couple to have a child.* (P1)

In the care with the maternal-child clientele in the HIV context, the participants emphasized possible contributions of the protocol to the knowledge of the reality experienced by the subject, creating bonds of trust and integrality in the care provided by the health team:

> *One advantage is providing the mother and child with an integral care, thus improving their health, promoting education and solving day-to-day problems.* (P1)

> [...] *I find it interesting, especially for the approach of professionals, of the service, of the staff to this clientele, creating bonds of trust, knowing their reality, difficulties, needs, so that we can intervene, solve.* (P4)

> *I think that, with this protocol, mothers and their children in the service will receive more attention. Since the reproductive planning, we will be able to follow-up the evolution, finding the difficulties and trying to solve them.* (P9)

Directing the eyes to the health demands of the HIV-positive mother and the child exposed to the HIV, as well as the issues concerning improvements in the health service and the satisfaction of professionals and users were also addressed:

> *The protocol is great, because it encompasses the mother-child care. Since the mother's health until the development of the child exposed to the HIV. It will bring many benefits for the health of this clientele and for the service's improvement.* (P3)

> [...] *it is awesome to be able to look up in the protocol for the child's vaccines, the main difficulties the mother can have with her child's and her health care, providing with greater problem solving concerning those cases.* (P4)

> [The protocol] *brings support, involvement of the staff for this clientele, in the HIV scenario. It has showed u show we can and we need to handle the mother and the child, promoting attention and satisfaction of professionals and this clientele.* (P8)

This thematic category evidenced that the protocol contributed to the organization of the work process, to greater approximation and bonding between staff and users, and for consistent responses to the health needs of people living with HIV, functioning as a guide to behaviors and actions towards the maternal-child clientele.

Deployment of the protocol in the teaching service of regional reference for HIV: facilities and difficulties

The implementation of a protocol in the health service specialized in HIV can be intertwined by facilitating and hindering factors in this process. The adequacy of the protocol prepared for the reality of the service, with possible contributions to the care with the mother and her child, was one of the facilities found:

> *The protocol will facilitate our service, we will be able to handle the maternal-child clientele in the HIV context, observe the records of the mother and the child, read the most important points and, thus, we will be able to handle every type of situation* (P3)

Issues relating to access to and knowledge of the protocol by all the staff members, as well as to the use of this tool as a trigger of discussions concerning assistance provided in the health service, were cited:

> *The protocol is easily accessed, there was an initial meeting to explain about the protocol and its target audience, they delivered a copy to all professionals at the service, it was well directed.* (P5)

> *Everyone had access to the files, I found the initiative very interesting.* (P7)

> *The protocol brought knowledge to the service, to the staff. We can discuss with all the assistance we provide and how we can improve it. So, it helps us, professionals at the service, intervene more effectively and have more positive outcomes.* (P10)

Some of the difficulties found in the implementation of the protocol were identified. The resistance regarding the use of the protocol by staff members at the teaching service, with possible negative repercussions on the assistance provided to the maternal-child clientele, appears in the reports:

> *We once had a case of a serum-discordant couple that wanted children, only the man was HIV-positive. We sent them to the doctor, but he was not able to handle the situation, so he discarded the possibility of the*

> *woman getting pregnant, that they could not, it would be a huge mistake. They both left here drained.* (P2)

> *It is complicated, the doctor is not licensed for the follow-up and, still, he does not seek knowledge, guidance. We will hand the doctor guidance function of the couple or the woman, and we will watch it very closely.* (P1)

> [...] *the doctors are very resistant, we are carrying out a qualification on the new PrEP* [Pre-Exposure Prophylaxis] *and we call them, little by little, we are managing to communicate with them, drawing their attention to this protocol, its importance to the service and whom it is going to benefit.* (P7)

The non-attendance of maternal-child clientele in the HIV context to the calls in the teaching service also appeared as a difficulty:

> *We do not know how we are bringing those patients to the consultation, we have to plan this, since the approach.* (P4)

> *Most of them do not come by lack of treatment adherence, they are ashamed and afraid of people finding out they are living with HIV.* (P8)

Other hindering factors that appeared in the reports relate to the great demand for visits, to the reduced size of the staff at the teaching service, and the barriers in the communication process between staff members:

> *Sadly, our staff is too small, we have the testing demand again, so we are rushing all the time. It is hard to care for this clientele so much, but we are going to solve it.* (P8)
> [...] *a difficulty we are managing to overcome, they* [doctors] *seem to be more active and communicating with the staff, we have so much to improve, but we have already gone far.* (P2)

This thematic category unveiled that the implementation of the protocol was a delicate process, permeated by facilitating and hindering factors. Some peculiarities of this tool, such as the suitability to the reality of the service and the accessibility, acted as facilitators. The difficulties encompassed issues related both to the staff, such as obstacles in the communicational process and some resistance to using the protocol, as to users, such as the non-attendance to the calls.

Discussion

The deployment of a protocol in the health service is a process that requires commitment and involvement of staff members and the clientele met for its realization. Protocols can provide better conditions for the care with the user according to the demand presented[14] and act as a tool for strengthening the care with the maternal-child clientele.

As shown by the results of a study on the incidence of vertical transmission cases developed in a teaching service reference for HIV, there is a need for a gaze directed to the systematization of practices related to maternal-child care.[2] As observed in the reports, the protocol can be recognized as an instrument that directs the qualified care.[11,15] In this sense, staff members pointed out possible contributions of the protocol to the organization of work processes in the teaching service, with reflections on the integrality of care with women and children.

The contributions of the protocol to expanding the eye of staff members to the different demands presented by the maternal-child clientele, with responses consistent with the reality experienced by this segment were also pointed out. It is important to point out that the construction of spaces for dialog can foster the survey of needs.[6] Furthermore, the creation of bonds with users of the health service may also contribute to an integral care.[4]

As evidenced in the reports of the staff members at the teaching service, the actions must be continuous, starting in reproductive planning, considering demands and needs of the woman and/or the couple. It is known that the diagnosis of HIV seropositivity can occur many times during the gestational period.[7] To reduce vertical transmission, the prenatal emerges as an opportune moment.[1]

During pregnancy, the inadequate control of maternal viral load can point to the risks of HIV transmission to the child.[5] Thus, an adequate control during pregnancy is important, with early diagnosis and treatment.[5] A study[6] shows the couple's involvement with the treatment and the care during the prenatal and childbirth, seeking to avoid the HIV vertical transmission to the child.

Concerning the prophylactic behaviors, the actions of counseling to women must be performed.[2] Educational actions also show important,[7] as well as the pediatric antiretroviral therapy, to prevent the infection of the fetus.[16] Therefore, there is a need for involvement of the healthcare professional, seeking a humanized assistance that ensures the sexual and reproductive rights.

There is need to recognize that public policies for the control of HIV vertical transmission must be strengthened.[17] Among the actions, there stand out the early acquisition of pregnant women by Primary Health Care (PHC) services and the training in counseling and clinical management of health professionals providing care to pregnant women and the parturient woman.[17]

Thus, actions aimed at HIV diagnosis and early initiation of prenatal care are important,[7] as well as the use of tools that can strengthen the care processes, such as the protocols. For the implementation of these care actions, it is necessary to strengthen the health staff's closeness and bond with the woman and/or couple. Here, there emerge the potentialities of the integrated work between the teaching service and other points of attention to maternal-child health of the

city. This shows that the different points in the health care network (PHC, reference service and maternity) must be articulated,[2] seeking an integral assistance.

The integrality in assistance to women and the family is stressed as essential for preventing vertical transmission, with actions structured and developed in different moments of attention, contemplating since the pre-conception until the post-natal.[2] The need for guarantee of integrality in attention was one aspect highlighted in the reports of the staff members at the teaching service.

In some moments, participants mentioned the possibility of surveying users' demands using the protocol. Considering the complexity involved in the process of motherhood in the scenario of HIV seropositivity, knowing the woman's needs emerges as essential, because she may have feelings and emotions that should be recognized and addressed by health professionals, coupled, for example, to the inability to breastfeed, which may cause difficulties and sorrow.[6]

Despite the recognition of the contributions of the protocol, the participants of this study pointed out difficulties for its deployment, such as the resistance of the medical professional to use this tool. In this scenario, they cited the evolution of a case concerning the possibility of pregnancy of a serum-discordant couple. Building relationships of trust with people living with HIV,[18] as well as the qualification of health care professional, are important in moments of attention to the pregnancy-puerperium cycle.

These difficulties found in the implementation of the protocol directs to the need for strengthening the communicative processes between the health staff members. Results of a study[11] reinforced the importance of health professionals' involvement and teamwork to the realization of the protocol. The literature points out that the health staff's unawareness of the protocol may emerge as a barrier.[10] In the teaching health service, as reported by participants, the

protocol was disclosure and is accessible to all staff members, which acted as a facilitator of the deployment process.

Other difficulties concerning the attendance of the maternal-child clientele to health services were mentioned. People with HIV can still face stigma associated with the HIV virus.[19-20] Thus, the lack of confidence in the health care team appears as a difficulty.[20] A study conducted in Mozambique points out the discrimination as one of the reasons for treatment abandonment.[19] The abandonment of antiretroviral treatment appears as a complex problem[19] to be faced by professionals working in health services. In this context, the protocol may contribute to reorganizing the processes of embracement of those users.

Before the results of the present study, it is inferred that different factors are interwoven in the process of realization of a protocol in the health service, such as encompassing users' needs, meeting the expectations of health professionals and being constructed according to the reality of the service.[14] In addition, the care should be built to promote the participation and empowerment.[6] The creation of bonds also appears as a strategy that can contribute to users' quality of life.[20] In this sense, when health professionals use the protocol, a tool for organization of the work process and management of care in the health service,[11] they should seek the development of health promotion actions, considering the importance of the involvement, participation and empowerment of women.[7]

Conclusion

The staff's perceptions pointed to the recognition of the potential of the protocol for the care with women and children, as well as to the need for integration and coordination of care, strengthening the bond and communicative processes in the health service studied.

The results suggest that nursing, as part of the health staff, can contribute to the organization of assistance to women and children in the HIV scenario, through the deployment of protocols, performing and intermediating actions to promote dialog, bond and the co-responsibility for the care.

As limitations, the present study depicts a contextualized action, which hampers generalizing the results achieved. Other qualitative researches, focused on the survey of perceptions of users of health services, such as women living with HIV, of the process of implementation of protocols, shall contribute to expanding the gaze on the object of study.

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