Access to and satisfaction with oral health care among persons with HIV/Aids in Northeastern Brazil

Satisfação e acesso à saúde bucal das pessoas que vivem com HIV/Aids no nordeste brasileiro

Lizaldo Andrade Maia[1], Anya Pimentel Gomes Fernandes Vieira-Meyer[2,3], Maria Vieira de Lima Saintrain[4], Sharmênia de Araújo Soares Nuto[3,4], Ana Patrícia Pereira Morais[5]

DOI: 10.1590/0103-11042021129121

ABSTRACT This study aimed to investigate, from the perspective of People Living with HIV/Aids (PLWHA), the use of and satisfaction with public oral health services within the Unified Health System (SUS) in Fortaleza (Northeastern Brazil). Structured questionnaires on socioeconomic profile and public oral health service use and satisfaction were administered to 241 PLWHA attending eight Specialized Healthcare Services (SAE) in HIV/Aids. The mean age was 37.8 ± 9.6 years, 161 (68.3%) were male, 79 (32.8%) had completed high school, and 59 (24.5%) reported earning ≤1 minimum wage (USD 225). Only 155 (64.3%) had been to the dentist in the preceding 2 years. Of these, 68 (28.2%) attended public services, but nearly half (45.6%) did not complete treatment due to lack of supplies, malfunctioning equipment or ongoing repair of facilities. On average, the service was graded 7.6 ± 2.5, and 50 PLWHA (73.6%) reported being satisfied/very satisfied. As for humanized care, 86.7% were satisfied/very satisfied. Patients referred by SAE or residing near the facility were significantly more likely to use public services. Despite the limited use of public oral health services, mainly due to insufficient access and ineffective appointment scheduling and referral procedures, the services were mostly graded as satisfactory.

KEYWORDS Oral health. Access to health services. HIV.

RESUMO *Este estudo objetivou avaliar, na perspectiva das Pessoas Vivendo com HIV/Aids (PVHA), uso e satisfação com os serviços públicos de saúde bucal no Sistema Único de Saúde em Fortaleza (CE). Aplicaram-se questionários estruturados sobre perfil socioeconômico, uso e satisfação dos serviços públicos de saúde bucal para 241 PVHA que frequentam 8 Serviços de Assistência Especializada em HIV/Aids. A idade média dos usuários foi de 37,8 ± 9,6 anos; 161 (68,3%) do sexo masculino; com ensino médio completo (n=79; 32,8%); 59 (24,5%) ganham até 1 salário mínimo (US$ 255). Apenas 155 (64,3%) foram ao dentista nos dois anos anteriores. Destes, 68 (28,2%) frequentavam serviços públicos, 31 (45,6%) dos quais não completaram o tratamento por falta de materiais/equipamentos defeituosos/reformas nas unidades de saúde. A nota média atribuída pelo paciente ao atendimento dos profissionais foi 7,6 (±2,5), 50 (73,6%) declararam-se muito satisfeitos/satisfeitos. Quanto ao atendimento humanizado, 59 (86,7%) estavam muito satisfeitos/satisfeitos. Pacientes encaminhados pelo Serviços de Assistência Especializada em HIV/Aids e os que residem perto das unidades de saúde tiveram probabilidade significativamente maior de usar os serviços públicos. Apesar do uso limitado dos serviços públicos de saúde bucal, principalmente devido ao acesso insuficiente e aos procedimentos ineficazes de agendamento, os serviços usados pelos entrevistados foram avaliados satisfatoriamente.*

PALAVRAS-CHAVE *Saúde bucal. Acesso aos serviços de saúde. HIV.*

[1] Secretaria Municipal de Saúde de Fortaleza (SMSF) – Fortaleza (CE), Brasil. *lizaldo@gmail.com*

[2] Centro Universitário Christus (Unichristus) – Fortaleza (CE), Brasil.

[3] Fundação Oswaldo Cruz (Fiocruz) – Fortaleza (CE), Brasil.

[4] Universidade de Fortaleza (Unifor) – Fortaleza (CE), Brasil.

[5] Universidade Estadual do Ceará (Uece) – Fortaleza (CE), Brasil.

Introduction

With the introduction of antiretroviral therapy for Acquired Immunodeficiency Syndrome (Aids) in the late 1990s, the life expectancy and quality of life of People Living with HIV/Aids (PLWHA) improved considerably. In addition, the number of new Human Immunodeficiency Virus (HIV) infections worldwide has decreased by 19% in the last decade[1]. Despite these advances, HIV/Aids remains a serious public health problem, mainly due to its high prevalence and high morbidity and mortality rates[2,3].

Worldwide, there were 37.9 million PLWHA in 2018[4]. In Brazil, from 1980 to 2019, 966,058 cases of Aids were identified; and 338,905 people died with HIV/Aids as the underlying cause between 1980 and 2018[3]. However, integrated care for PLWHA – from health promotion measures and disease prevention to recovery and multidisciplinary monitoring – is still a challenge in the care setting. to public health[5], despite the strong legislation supporting this population[6].

It is important to emphasize that health promotion is conceptualized as a determinant and conditioner of health because it is concerned with the population's way of life, with its economic, environmental, ecological, and cultural factors; incorporating targeted policy initiatives[7,8]. The prevention of diseases, in turn, seeks the absence of disease, with a focus on epidemiological knowledge, aiming to control transmission and reduce the risk of health problems[9].

The increasing survival of PLWHA implies a growing demand for oral health care. The training and willingness of dentists to treat PLWHA is essential for integrated care, mainly because of the early onset of Aids-related injuries in the oral cavity. Such lesions are seen in up to 80% of patients with this syndrome, being an important marker of immunosuppression[10].

Created in 1988, anchored on the principles of universality, equity, and integrated care, the Unified Health System (SUS) offers primary, secondary, and tertiary care to all people[11]. The SUS is the first health system in a developing country to provide free and universal access to the treatment of PLWHA, including the systematic free distribution of antiretroviral drugs[6].

In the 1990s, the Ministry of Health of Brazil encouraged state and municipal governments to implement the Specialized Healthcare Services in HIV/Aids (SAE), which is responsible for monitoring patients, including referrals of HIV-positive patients for dental care in primary care and dispensing of antiretroviral medication[12].

The SUS provides a wide range of Primary Health Care (PHC) services under the aegis of the Family Health Strategy (ESF). Access to PHC services is provided by Family Health Teams (EqSF), which include doctors, nurses, nursing assistants and community health agents. Since the year 2000, the ESF has also been assisted by Oral Health Teams (ESB)[13]. Each ESF/ESB, installed in the Family Health Centers (CSF), covers a specific geographic area[14] and, if necessary, forwards patients to Dental Specialty Centers (CEO). In 2019, the ESF covered 96% of Brazilian municipalities, corresponding to 64.2% of the population. Likewise, in the same year, 28,79[7] ESB were implemented throughout the country, corresponding to a coverage of 42.8% of the population[15]. In the municipality of Fortaleza, Ceará (CE), in addition to the 8 SAE, the Care Network, in 2019, was composed of 109 CSF, 10 municipal public hospitals (secondary and tertiary care), 9 Emergency Care Units (UPA); 11 Psychosocial Care Centers (Caps), 4 CEO, and 4 Polyclinics. Information from the National Register of Health Establishments (CNES) reveals a coverage of the ESF in the city of 56% (379 EqSF) and 33% of Oral Health (260 ESB)[15].

Studies have shown low average levels of education and income among PLWHA[16,17], indicating that an important part of this

population depends on public services for their health needs. However, little is known about access, use of services, and satisfaction with public oral health services in countries with free universal health systems such as Brazil. Thus, the aim of this study was to evaluate, from the perspective of PLWHA, the use and satisfaction of public oral health services in a large Brazilian city.

Material and methods

Quantitative, descriptive, and analytical study carried out in all SAEs in Fortaleza (CE). Located in the Northeast region, it is the fifth largest capital in Brazil (2.5 million inhabitants). In this poor region, the Aids detection rate is above the national average in 2018 (Fortaleza and Brazil, detection rates 26.4 and 17.8 per 100,000 inhabitants, respectively)[3,18].

The study population consisted of 2,153 PLWHA residing in Fortaleza (CE) and registered in all eight municipal SAEs, according to secondary data obtained from the Epidemiological Surveillance Service of the municipality and the Coordination of Sexually Transmitted Diseases/Aids/Viral Hepatitis. With the level of statistical significance set at 90% and the sampling error at 5%, a sample size of 241 individuals was calculated.

To be included as a participant in the study, it was necessary to be PLWHA, user of one of the SAEs in Fortaleza (CE). PLWHA were proportionally recruited in all eight SAEs. After a routine consultation with infectologists, the patient was asked if he could participate in the research by the physician. These professionals were previously contacted by the researcher, being sensitized to support the research. All infectologists agreed to participate in the recruitment of patients for the present study. Patients were referred to the researcher after being accepted to participate in the research. Patients were excluded from the sample if: i) they lived outside Fortaleza (CE); ii) were under 18 years of age; iii) were on their first appointment; and iv) had been diagnosed with HIV for less than two years. The information was collected through a structured questionnaire, applied in person in 2013 by a single researcher in a private room, including questions about the socioeconomic level, use and satisfaction of the public oral health service, humanized care and health care processes, as defined by Donabedian[19].

In the statistical software Epidata 3.1., the database was built, being processed and analyzed in the Statistical Package for Social Science (SPSS) 19.0 for Windows (SPSS Inc, Chicago, IL, USA). Descriptive results were processed using simple frequencies and percentages. In addition, the analysis of associations between categorical variables was performed by cross-referencing, calculating Pearson's chi-square test (x^2). The p value was considered significant when less than or equal to 0.05.

All participants were informed of the objectives and methodology of the study and signed the Informed Consent Form. The research complied with all ethical precepts of Resolution No 466/2012, having been approved by the Research Ethics Committee of the State University of Ceará under number 357.459.

Results

A total of 241 PLWHA, proportionally distributed among the 8 SAEs in Fortaleza (CE), were included in the survey. Seven subjects refused to participate. Mean age was 37.8 ± 9.6 years (range: 18-65). Most were male (n=161; 68.3%), brown (n=183; 75.9%), single (n=152; 63.1%), with high school education (n=79; 32.8%), without children (n=126; 52.3%). Regarding economic conditions, 49 (20.3%) have no income, 59 (24.5%) earn up

to one minimum wage and 83 (34.4%) earn between one and two minimum wages – at the time of writing this article, the official minimum wage was equivalent to R$ 998.00 (US$ 255) per month.

Regarding the use of the public oral health service, 122 (50.6%) reported receiving dental treatment in private clinics, 78 (32.4%) had health insurance, 68 (28.2%) attended public services (CSF/CEO), 44 (18.3%) used services provided by unions, 16 (6.6%) were attended at the Faculty of Dentistry, and 5 (2.0%) had funeral insurance with dental coverage. Only 155 (64.3%) of respondents had been to the dentist in the last 2 years, 83 (34.4%) had been to the dentist for more than 2 years and 3 (1.2%) had never received oral health care. In the first subset, 120 (77.4%) were routine appointments; 19 (12.6%), emergencies; and 16 (10.3%) were specialized care.

Respondents reported attending public services such as CSF (n=61; 25.3%) and CEO (n=7; 2.9%) or other services (n=173; 71.8%). Half (n=34; 50%) of the PLWHA who use public services (CSF/CEO) did so by spontaneous demand, while 19 (27.9%) were referred by the SAE. Almost two-thirds (64.7%; n=44) of patients using the public health system reported that their oral health problem had been resolved. *Table 1* shows the evaluation of respondents who used the public health system in relation to ease of access, problem solving, and treatment completion (n=68).

Table 1. Means of access, problem resolution and complete treatment in oral health services (CSF/CEO). Information on PLWHA registered in the municipal SAE. Fortaleza (Ceará, Brazil) – n=68

	n	%
How did you get access to the consultation?		
Referenced by SAE	19	27.9
By scheduling with the ACS or ASB	3	4.4
Register distributed on the day	34	50.0
Other	12	17.7
Are you satisfied with the way you got access to the consultation?		
Yes	56	82.4
No	10	14.7
Partly	2	2.9
Do you think your problem has been resolved?		
Yes	44	64.7
No	21	30.9
Partly	3	4.4
Did the dentist complete the treatment?		
Yes	37	54.4
No	31	45.6
Why didn't the dentist complete the treatment?		
Lack of material, equipment problem, or CSF under renovation	18	58.1
Dentist missed work	2	06.4

Table 1. (cont.)

	n	%
Dentist did not schedule the return	4	12.9
Patient missed the appointment and did not reschedule	3	9.7
Dentist knew the user was HIV+, told him to look for another CSF	4	12.9

Souce: Our own elaboration.

CSF = Family Health Center (Centro de Saúde da Família); CEO = Dental Specialties Center (Centro de Especialidades Odontológicas); SAE = Specialized Healthcare Services in HIV/Aids (Serviço de Assistência Especializada em HIV/Aids). ACS = Community Health Agent (Agente Comunitário de Saúde); ASB = Oral Health Assistant (Auxiliar em Saúde Bucal).

Table 2 shows the results of the assessment of patients in a sub-sample of 39 people who received oral health care in public (CSF/CEO) and private clinics. Two of them (5.2%) considered CSF/CEO better or much better than private clinics, 19 (48.7%) rated CSF/CEO worse or much worse, while 18 (46.1%) deemed the two options to be similar. Many users of public health services reported having omitted their HIV-positive status during dental appointments (n=16; 23.5%). Fourteen (87.6%) did so for fear of discrimination or denial of the appointment.

Table 2. Participation in educational activity, comparison of public and private services and discrimination or resistance by the team in oral health services (CSF/CEO). Information on PLWHA registered in the municipal SAE. Fortaleza (Ceará, Brazil) – n = 68

	n	%
Did you participate in an educational activity with an oral health team?		
Yes	18	26.5
No	50	73.5
If so, was it satisfactory?	**18**	**100.0**
If you were seen in a private service (hospital, doctor's office, health insurance), how would you rate the service provided by the CSF/CEO?*		
Much better	1	2.6
Better	1	2.6
Same	18	46.1
Worse	15	38.4
Much worse	4	10.3
Did you experience any form of discrimination / prejudice during the service?		
Yes	2	2.9
No	66	97.1
Did you notice any kind of resistance on the part of the dentist or the assistants in seeing you or during the care?		
Yes	4	5.9
No	64	94.1

Table 2. (cont.)

	n	%
Have you ever omitted that you are HIV+ during dental care at CSF/CEO?		
Yes	16	23.5
No	52	76.5
If so, why did you omit it?		
Fear of discrimination	09	56.3
Fear of not being seen	5	31.3
Dentist knew the patient's family	1	6.3
Thought you shouldn't talk	1	6.3

Souce: Our own elaboration.

CSF = Family Health Center (Centro de Saúde da Família); CEO = Dental Specialties Center (Centro de Especialidades Odontológicas); SAE = Specialized Healthcare Services in HIV/Aids (Serviço de Assistência Especializada em HIV/Aids).

* Based on a sub-sample of 39 patients who received care at both the CSF/CEO and private clinics.

Table 3 shows the respondents' responses regarding location, physical structure and availability of supplies in public health units (CSF/CEO). Only 68 (28.2%) attended public services, 31 (45.6%) did not complete treatment for various reasons, including lack of materials/supplies, defective equipment or infrastructure reforms at the health facility. Almost half (n=32; 47.1%) considered the physical structure adequate, while 28 (41.2%) confirmed the availability of the necessary supplies to treat their condition.

Table 3. Physical structure of the dental office and its distance to the user's residence. Information on PLWHA registered in the municipal SAE. Fortaleza (Ceará, Brazil) – n=68

	n	%
Is the physical structure of the CSF/CEO office adequate for the service?		
Yes	32	47.1
No	15	22.1
Partly	3	4.4
I don't know	18	26.5
Does the CSF/CEO office have all the necessary materials for the service?		
Yes	28	41.2
No	22	32.4
Partly	5	7.4
I don't know	13	19.1
Over the last 12 months, has the service stopped due to lack of material or maintenance?		
Yes	38	55.9
No	1	1.5
I don't know	29	42.6

Table 3. (cont.)

	n	%
If so, for how long?		
Between two and four weeks	2	5.3
Between one and two months	9	23.7
Between two and four months	13	34.2
Between four and six months	9	23.7
Between six months and one year	3	7.9
More than one year	1	2.6
I don't know	1	2.6
Do you live in the neighborhood near the CSF/CEO where you were seen?		
Yes	42	61.8
No	26	38.2
If not, why was choose the care service away from the neighborhood where you live?		
User request	11	42.3
Referral of the SAE	11	42.3
Other	4	15.4
Did you have difficulty moving from your home to the CSF/CEO where you were treated?		
Yes	9	13.2
No	59	86.8

Source: Our own elaboration.

CSF = Family Health Center (Centro de Saúde da Família); CEO = Dental Specialties Center (Centro de Especialidades Odontológicas); SAE = Specialized Healthcare Services in HIV/Aids (Serviço de Assistência Especializada em HIV/Aids).

When CSF/CEO users were asked to rate the care received (0-10), the mean score was 7.6 ± 2.5. Three quarters (n=50; 73.6%) were satisfied/very satisfied with the service, while one quarter (n=18; 26.5%) were not very satisfied/dissatisfied. *Table 4* shows the responses of users of the CSF/CEO in relation to humanized care practices observed during the consultation.

To verify the association between the use of the public oral health care service and the variables in *tables 1 to 4*, the findings were submitted to cross tabulation and the chi-square test. The results indicate that patients referred by the SAE and patients living close to health facilities were significantly more likely to use public services ($p \leq 0.001$ and $p \leq 0.01$ respectively).

Table 4. Devices for the humanization of care in oral health services (CSF/CEO). Information on PLWHA registered in the municipal SAE. Fortaleza (Ceará, Brazil) – n=68

	n	%
Is the dentist prepared to solve the patient's oral health problems?		
Yes	57	83.8
No	6	8.8
Partly	1	1.5
I don't know	4	5.9
Degree of general satisfaction with the dentist's service		
Very satisfied	15	22.1
Satisfied	35	51.5
Little satisfied	10	14.7
Dissatisfied	8	11.8
Regarding respect and attention in dental care		
Very satisfied	23	33.8
Satisfied	36	52.9
Little satisfied	6	8.8
Dissatisfied	3	4.4
Regarding the transfer of information clearly during the service by the dentist		
Very satisfied	19	27.9
Satisfied	31	45.6
Little satisfied	11	16.2
Dissatisfied	7	10.3
Regarding the reception, listening to the complaint, understanding the fears, anxieties, vulnerability, on the part of the dentist		
Very satisfied	27	39.7
Satisfied	28	41.2
Little satisfied	5	7.4
Dissatisfied	8	11.8
Regarding the dentist's effort to seek interactions with other EqSF professionals or help from other sectors in order to meet all their patient needs		
Very satisfied	4	5.9
Satisfied	2	2.9
Little satisfied	1	1.5
Dissatisfied	3	4.4
I don't know	58	85.3

Souce: Our own elaboration.

CSF = Family Health Center (Centro de Saúde da Família); CEO = Dental Specialties Center (Centro de Especialidades Odontológicas); SAE = Specialized Healthcare Services in HIV/Aids (Serviço de Assistência Especializada em HIV/Aids); EqSF = Family Health Team (Equipe de Saúde da Família).

Discussion

Due to its amplitude, this study allowed a better understanding of the use and satisfaction regarding the public oral health service among PLWHA and some of the aspects that can moderate its use from the perspective of these people. Furthermore, the level of satisfaction of PLWHA with the quality, access, and resoluteness of services enables an understanding of the challenges faced by free universal systems that encompass oral health care, serving as a basis for the formulation of public policies in the field.

The sample of this investigation is considered representative of the general population of PLWHA living in Fortaleza (CE), as they were interviewed where antiretroviral drugs are dispensed. Due to the high cost of antiretroviral drugs and their free distribution through the SUS, it is unlikely that a significant proportion of PLWHA would not use the public health system to purchase their drugs.

Integrated care by multidisciplinary teams is necessary to minimize the risk of avoidable health[2]. However, the limited access of PLWHA to oral health care is a serious problem, considering that they have a greater need for this care than the general population[20,21]. Unmet oral health care needs are common among PLWHA, and barriers to care seem to be associated with race and socioeconomic status[22]. In fact, as demonstrated by the socioeconomic indicators surveyed, the needs for oral health care are substantial in these patients. Only a third of those interviewed had completed high school, a quarter had no income, and the majority earned less than two minimum wages. These findings are corroborated by other studies that indicate low levels of education and income among PLWHA[16,17]. Due to unfavorable socioeconomic and educational conditions, a significant proportion of PLWHA depend exclusively on the SUS and are in urgent need of access to public services.

In a study based on a population sample from the United States of America (USA), almost half of the participants reported having unmet oral health needs after being diagnosed with HIV[22]. In Mississippi, oral health care and oral examination were the most frequently unmet needs among PLWHA[23]. However, it is necessary to understand that the comparison between Brazil and the USA cannot be direct, given the discrepancy between the health care models used in the two countries. While Brazil has a public, universal and free system, which encompasses oral health, the USA has a private system, accessed by the majority of the population via health insurance, which does not always include oral health in the list of available procedures[24]. Thus, the low access of PLWHA patients among North Americans is understandable, which would not be so predictable in the Brazilian system.

In a sample of Nigerian patients, unmet needs were reported by 79.4%[25]. A Brazilian study demonstrated a high demand for oral health care services in PLWHA[16]. On the other hand, participation in government programs aimed at improving access to oral health care was associated with general well-being in low-income PLWHA[26], which should encourage these patients to seek oral health care. However, in this study, the use of free public health services was limited, as only a quarter of the sample reported that they got care at the CSF/CEO.

Understanding the importance of oral health care in the quality of life of PLWHA, we sought to understand how it is being performed in the researched group. The results revealed that more than a third of the interviewees had not seen a dentist in the last two years, and that, of those who were seen, more than half had dental treatment using private services. In this context, it is important to mention that the findings by Cavalcante et al.[27] and Araújo[16] highlight that 21.0% and 45.1% of users, respectively, claimed to have consulted a dentist for less

than a year; while in a study in the USA, most patients (52.4%) had not consulted a dentist for more than two years, 48.2% reported one or more oral needs not met after HIV diagnosis, and 63.2% classified the health of their teeth and gums as 'fair' or 'poor'[27]. Considering that the costs of private dental services are high and that the population studied, for the most part, is of low socioeconomic status, the interest of PLWHA in dental consultation and a low accessibility of public dental services to this population. This highlights the importance of developing strategies to reduce costs, increase use and reduce personal barriers to oral health care, especially considering the impact of poor oral health among this population[22].

In addition, there is the concern about the difficulty of access to health services by this population, the low level of health education activities developed by the ESB to PLWHA. More than two thirds of SUS users who were assisted in the CSF/CEO did not participate in this educational activity, results in agreement with other studies[16,27]. This finding is worrisome, given that oral health care impacts the quality of life of PLWHA[28], especially when supported by health education for the prevention of periodontal diseases, as well as opportunistic oral infections[2].

However, having access to the public oral health care service does not mean resoluteness/completion of treatment. Almost half of users reported not having completed their dental treatment. Lack of materials, equipment problems, or renovations to the CSF were the reasons most cited by PLWHA who did not complete dental treatment. These difficulties, along with the overcrowding and lack of vacancies in the CSF, were described by almost all users who tried but were unable to be assisted in municipal services. These findings indicate a serious problem of access and problem-solving in the care of PLWHA seeking public oral health care in Fortaleza (CE). Araújo[16] highlights the lack of vacancies in public services as the main problem for PLWHA to get access to dental appointments, pointed out by 46.2% of users. In addition, the author highlights the professionals' refusal of care as a relevant inconvenience. This may explain the high percentage of patients who omit their HIV-positive status to dental professionals[23].

Discrimination, or the fear of it, can induce PLWHA to self-discriminate in their search for dental care, causing them to hide their seropositivity and/or seek treatment far from their home, where, theoretically, they are less known, and, consequently, they end up having less connection with the service and greater access difficulties. Corroborating the results of the literature[16,17,23,25-27], the present investigation showed that more than a third of the users who had access to the CSF/CEO were assisted far from the neighborhood in which they live; and, of these, when referred by the SAE to the dentist, almost half requested care far from their home.

Researches showed that more than half of PLWHA did not reveal their serological status to the dental surgeon before dental treatment. The main justifications of these people for omitting their HIV-positive status are the fear of refusal of care and the fear of being discriminated against or treated with prejudice[16,17]. Likewise, in the present investigation, almost a quarter of the users seen stated that they had already omitted the HIV-positive status during dental care. Almost 90% mentioned fear of being refused in their care or being discriminated against as reasons.

Difficulties in accessing the service can be a consequence of the vulnerability and prejudice that this group suffers. They may also be related to the precarious humanistic and technical training of health professionals; with the way of the work process of the EqSFs, which do not favor the creation of a bond with the user and the living territory; with

the non-prioritization of vulnerable groups, which may allow discrimination (explicit or implicit) to be installed in the CSF; with the social, cultural, economic and political structure of society. These issues can be considered as structural violence against PLWHA, which is expressed in unequal opportunities, discrimination and injustice, such as, for example, access to education and health services. Johan Galtung[29] defines it as violence that is not practiced by a concrete agent with the objective of inflicting suffering, but is generated by the social structure itself. Structural violence is not necessarily an active and deliberate process, it can be revealed by the absence of protection and guarantee of rights and needs. It is closely linked to social injustice, as it affects people in different ways within different social structures[30]. These aspects lead, then, to the reflect upon the importance of applying the principles of ethics and bioethics in the care of PLWHA, since discriminatory and prejudiced environments, which generate invasion of privacy, make it difficult to assist this group of users[31], and can compromise their access and adherence to treatment, affecting their health.

Considering all these issues under discussion, it was also evidenced that, in order to carry out a resolute and continuous oral health care, it is essential to guarantee the user's adherence to the treatment, in addition to wide access and good quality of service. Therefore, the practice of humanized care for PLWHA, by the ESB, can significantly contribute, supporting these users in the continuity of treatment. The humanization of care must be carried out in the daily service, establishing a good professional-patient relationship and seeking to improve the quality of life of users[32]. Technically, humanization means quality care, associated with the recognition of patients' subjectivity, rights and cultural references[33]. In this sense, the humanization of care seeks to change the relationships between workers and users and among workers, establishing a bond/responsibility of teams with users. Autonomy must be respected, considering its uniqueness, and, when it comes to care for PLWHA, its vulnerability, taking into account the subjectivity of the disease[32,33].

Regarding the humanized care practices observed during the consultation of PLWHA, it was found, in this present study, a score of 7.6 (±2.5) attributed by patients to the care provided by the dentist. Most users interviewed believe that the professionals who saw them were prepared to solve their oral health problems, declaring themselves very satisfied or satisfied in relation to the level of general satisfaction with the service. More than 70% of the PLWHA seen at the CSF/CEO marked very satisfied or satisfied, considering the respect, attention, and clear transfer of information during the service.

In contrast to a previous study[34], in the present investigation, when the PLWHA seen at the CSF/CEO were asked if they had already experienced any form of discrimination and/or prejudice during dental care, or if they had observed any type of resistance on the part of the professionals in assisting them, only a very low percentage answered yes. This finding is relevant, as it proves that, at least from the perspective of the PLWHA attended, the ESB has been able to offer humanized care, considering the results discussed. In other words, the professionals who are willing to assist PLWHA do it in a way that is humanized and free from prejudice.

It is interesting to emphasize, as discussed above, that greater user adherence to treatment involves several issues, ranging from accessibility (for example, distance of the health unit from their residence, availability of appointments), to presence of dental material in the necessary quantity and quality, professionals who are qualified for the service and able to welcome and solve the patient's demands, to more subjective issues, such as humanization of care and creation of a patient-professional bond. Thus, it is necessary that public policies aimed at the care of those patients understand and work on these aspects, focusing on professional training, the organization of the care

network, the qualification of the referral and counter-referral process, the structuring of oral health services, among others aspects.

Final considerations

We can conclude that humanized dental care for PLWHA in the CSF/CEO of Fortaleza (CE) may be a fundamental tool in the process of user adherence to treatment, as well as its importance in the evaluation of these services. Thus, the methodology used in this study allowed a description of the reality, with most users declaring themselves satisfied with the quality of the dental service provided by the ESB, although complaints were observed regarding the interruption of treatment caused by the lack of physical resources and materials. It is evident, therefore, that oral health care for PLWHA in Fortaleza (CE) is difficult to access and has obstacles in the scheduling and referral procedures of patients. Professionals willing to treat PLWHA were perceived as offering a satisfactory level of care, although significant advances in access to antiretroviral drugs and the establishment of reference centers for PLWHA, integrated public health services – including oral health care – are still at an early stage.

This study highlighted the importance of integrated care for PLWHA, requiring the distribution of antiretroviral drugs, which proves to be insufficient to fully support the quality of life of these patients. Furthermore, this research may contribute to a relevant discussion about these issues while taken into account by systems that intend to face the challenge of caring for PLWHA.

Collaborators

Maia LA (0000-0003-0634-1757)*, Vieira-Meyer APGF (0000-0003-4237-8995)*, Saintrain MVL (0000-0003-1514-3218)*, Nuto SAS (0000-0002-4763-6773)* and Morais APP (0000-0001-6188-7897)* have equally contributed in the conception and planning of the research; for analysis and interpretation of data, and for writing and approval of the final version of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. World Health Organization. Global health sector strategy on HIV/AIDS 2011-2015. Geneva: World Health Organization; 2011.

2. Buchala CM, Cavalheiro TR. A classificação internacional de funcionalidade, incapacidade e saúde e a aids: uma proposta de core set. Acta Fisiatrica. 2008; 15(1):42-8.

3. Brasil. Ministério da Saúde. Boletim epidemiológico HIV/AIDS. Brasília, DF: Ministério da Saúde; 2019 [acesso em 2020 jan 10]. Disponível em: http://www.aids.gov.br/pt-br/pub/2019/boletim-epidemiologico-de-hivaids-2019.

4. Report on the global AIDS epidemic. Relatório Informativo. Geneva: UNAIDS 2019. [acesso em 2019 dez 6]. Disponível em: https://unaids.org.br/wp-content/uploads/2019/11/2019_UNAIDS_WAD2019_FactSheet.pdf.

5. Naidoo P. Barriers to HIV Care and Treatment by Doctors: A review of the literature. S Afr fam pract. 2006; 48(2):55-16e.

6. Brasil. Lei nº 9.133, de 13 de novembro de 1996. Dispõe sobre a distribuição gratuita de medicamentos aos portadores do HIV e doentes de AIDS. Diário Oficial da União. 14 Nov 1996. [acesso em 2019 set 16]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l9313.htm.

7. Silva KL, Sena RR, Grillo MJC, et al. Formação do enfermeiro: desafios para a promoção da saúde. Esc Anna Nery Rev Enferm. 2010 [acesso em 2012 set 12]; 14(2):368-376. Disponível em: http://www.scielo.br/pdf/ean/v14n2/21.pdf.

8. Mooneya B, Timminsb F, Byrneb G, et al. Nursing students' attitudes to health promotion to: Implications for teaching practice. Nurse educ. today. 2011 [acesso em 2013 ago 15]; 31(8):841-848. Disponível em: http://www-sciencedirect-com.ez18.periodicos.capes.gov.br/science/article/pii/S026069171000256X#bb0255.

9. Czeresnia D. O Conceito de Saúde e a diferença entre Prevenção e Promoção. In: Czeresnia D, Freitas CMF, organizadores. Promoção da Saúde, conceitos, reflexões, tendências. Rio de Janeiro: Fiocruz; 2003.

10. Coogan MM, Greenspan J, Challacombe SJ. Oral lesions in infection with human immunodeficiency virus. Bull World Health Organ. 2005; 83(9):700-706.

11. Barros AJD, Santos IS, Bertold ID. Can mothers rely on the Brazilian health system for their deliveries? An assessment of the use of public system and out of- pocket expenditure in 2004 Pelotas Birth Cohort Study, Brazil. BMC Health e Serv Res. 2008; (8):57-63.

12. Borges MJL. Integralidade da atenção à saúde das pessoas vivendo com HIV/Aids: uma avaliação de serviços de assistência. [dissertação]. Recife: Fundação Oswaldo Cruz; 2010. 137 p.

13. Giovanella L. Atenção Primária à Saúde: seletiva ou coordenadora dos cuidados? Rio de Janeiro: Cebes; 2008.

14. Brasil. Ministério da Saúde. Diretrizes da política nacional de saúde bucal [internet]. Brasília, DF: Ministério da Saúde; 2004. [acesso em 2019 dez 6]. Disponível em: http://dab.saude.gov.br/portaldab/biblioteca.php?conteudo=publicacoes/pnsb.

15. Brasil. Ministério da Saúde. Portal Brasil. Informação e Gestão da Atenção Básica. Histórico de Cobertura. 2019. [acesso em 2019 dez 5]. Disponível em: https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaConsolidado.xhtml.

16. Araújo DB. Condições de saúde bucal e utilização de serviços odontológicos por pessoas que vivem com HIV/AIDS no município de Fortaleza-Ceará. [dissertação]. Fortaleza: Universidade Federal do Ceará; 2010. 110 p. [acesso em 2019 set 7]. Disponível em: http://www.repositorio.ufc.br/bitstream/riufc/1011/1/2010_dis_dbaraujo.pdf.

17. Pires MBO, Martelli Júnior H, Melo Filho MR, et al. Dificuldades percebidas por pacientes vivendo com HIV/AIDS em obter tratamento odontológico. Arq Odontol. 2008; 44(3):25-31.

18. Ceará. Secretaria de Saúde do Estado. Boletim Epidemiológico HIV/Aids. Fortaleza; 2019. [acesso em 2020 jan 12]. Disponível em: saude.ce.gov.br/wp-content/uploads/sites/9/2018/06/BOLETIM_-AIDS_-2019_29_11_2019.pdf.

19. Donabedian A. The quality of care. How can it be assessed? JAMA. 1988; 260(12):1743-1748.

20. Jones J, Mofidi M, Bednarsh H, et al. Increasing access to oral health care for people living with HIV/AIDS in rural Oregon. Public Health Rep. 2012; 127(supl2):65-72.

21. Fox JE, Tobias CR, Bachman SS, et al. Increasing access to oral health care for people living with HIV/AIDS in the U.S.: baseline evaluation results of the Innovations in Oral Health Care Initiative. Public Health Rep. 2012; 127(supl2):5-16.

22. Jeanty Y, Cardenas G, Fox JE, et al. Correlates of unmet dental care need among HIV-positive people since being diagnosed with HIV. Public Health Rep. 2012; 127(supl2):17-24.

23. Krause DD, May WL, Butler Jr KR. Determining unmet, adequately met, and overly met needs for health care and services for persons living with HIV/AIDS in Mississippi. AIDS Care. 2012; 25(8):973-979.

24. Noronha JC, Ugá MAD. O sistema de saúde dos Estados Unidos. In: Buss PM, Labra ME, organizadores. Sistemas de saúde: continuidades e mudanças. Rio de Janeiro: Editora Fiocruz; 1995. 265 p. [acesso em 2019 set 30]. Disponível em: http://books.scielo.org.

25. Adedigba MA, Ogunbodede E, Jeboda SO, et al. Self-perceived and unmet general health need among PLWHA in Nigeria. East Afr J Public Health. 2008; 5(3):199-204.

26. Bachman SS, Walter AW, Umez-Eronini A. Access to oral health care and self-reported health status among low-income adults living with HIV/AIDS. Public Health Rep. 2012; 127(supl2):55-64.

27. Cavalcante CAT, Gonçalves DHA, Maia DKA, et al. A atenção em saúde bucal para DST/HIV/AIDS na rede municipal de Belo Horizonte: diagnóstico loco-regional. Belo Horizonte: Secretaria Municipal de Saúde; 2006. [acesso em 2015 ago 18]. Disponível em: http://www.pbh.gov.br/smsa/biblioteca/saudebucal/atencaoemsaudebucalparadsthivaids.pdf.

28. Brown JB, Rosenstein D, Mullooly J, et al. Impact of intensified dental care on outcomes in human immunodeficiency virus infection. AIDS Patient Care STDS. 2002; 16(10):479-86.

29. Galtung J. Violence, Peace, and Peace Research. J Peace Res. 1969; 6(3):167-191.

30. Farmer PE, Nizeye B, Stulac S, et al. Structural Violence and Clinical Medicine. PLOS Med. 2006; 3(10):1686-1691.

31. Carneiro HG. Ética e Bioética no atendimento aos pacientes portadores de HIV/aids no Sistema Único de Saúde. Cad IberAmer Direito Sanit. 2013; 2(2):839-849.

32. Campos GWS. Humanização na saúde: um projeto em defesa da vida? Interface (Botucatu). 2005 [acesso em 2019 ago 27]; 9(17):398-403. Disponível em: http://www.scielo.br/pdf/icse/v9n17/v9n17a16.pdf.

33. Deslandes SF. Análise do discurso oficial sobre a humanização da Assistência hospitalar. Ciênc. Saúde Colet. 2004; 9(1):7-14.

34. Andrade JT, Holanda VMS, Gondim APS. Em busca do humano: avaliação do Humaniza SUS em ações municipais de saúde em Fortaleza. Relatório Final. Observatório de Recursos Humanos em Saúde – CETREDE / UFC; Fortaleza: Núcleo de Pesquisa em Educação e Saúde Coletiva – UECE; 2007. [acesso em 2015 set 30]. Disponível em: http://www.observarh.org.br/observarh/repertorio/Repertorio_ObservaRH/CETREDE/Busca_humano.pdf.

Received on 03/15/2020
Approved on 11/05/2020
Conflict of interests: non-existent
Financial support: non-existent