

Frontline health professionals' perceptions about HIV and youth

Percepções dos profissionais de linha de frente da saúde sobre HIV e juventudes

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ABSTRACT Discussions about HIV are still permeated with stigmas and placing blame on individuals for their behavior. Public policies, including those related to HIV/AIDS, are based on political categories that can generate symbolic effects, either by reproducing or confronting stigmas. The literature points out that frontline health workers (TLF) apply personal and professional values in their interactions with service users, and that these values may be influenced by social or political categories. This article aims to understand how TLF operate such categories in institutional contexts that might be ambiguous, as well to analyze whether TLF's perceptions of categories related to risk behavior and youth are in line with public policies. We analyzed 8 policy documents and interviewed 42 workers from 6 health services. The materials were coded, the official categories were compared and the practices were identified. The findings suggest that social and political categories have mutual influences. Political categories are still legitimized through social perceptions of normalcy and risk, especially as it relates to priority populations. Social categories, which operate in policy implementation, reinforce stigmas and moral judgments about certain young people, such as blacks and the poor, single mothers and those who belong to the LGBTQIA+ community. Specialized services utilize political categories more than primary care services.

KEYWORDS Public policy. Adolescent. Occupational groups. Social stigma. HIV.

RESUMO *A temática do HIV ainda é permeada de estigmas e culpabilização de indivíduos por seus comportamentos. Políticas públicas, incluindo a de HIV/Aids, são baseadas em categorias políticas que geram efeitos simbólicos, reproduzindo ou enfrentando estigmas. A literatura afirma que Trabalhadores da Linha de Frente (TLF) mobilizam valores pessoais e profissionais nas interações com os usuários, que podem incluir categorias sociais ou políticas. Este artigo objetivou compreender como TLF operam tais categorias em contextos institucionais de ambiguidade, bem como analisar se suas percepções com relação às categorias de comportamento de risco e juventude estão em consonância com as políticas públicas. Foram analisadas 8 normativas e entrevistados 42 trabalhadores de 6 serviços de saúde. Os materiais foram codificados, as categorias oficiais foram comparadas, e as práticas, identificadas. As conclusões sugerem que as categorias sociais e políticas têm influência mútua. As categorias políticas ainda são legitimadas por meio de percepções sociais de normalidade e risco, especialmente ao lidar com populações prioritárias. As categorias sociais, operadas na implementação reforçam estigmas e julgamentos morais sobre alguns jovens, como os negros e pobres, as mães solteiras e a comunidade LGBTQIA+. Os serviços especializados utilizam mais as categorias políticas do que os serviços de atenção primária.*

PALAVRAS-CHAVE Política pública. Adolescente. Categorias de trabalhadores. Estigma social. HIV.

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Introduction

Social policies are based on categorization processes of citizens in those who have or not the right to a specific service¹⁻³. Although the normatives propose categories of citizens with rights, the concrete processes of categorization occur during the implementation of public policies, when the frontline workers (TLF) decide who receives what⁴. The TLF adapt official categories and introduce other non-official to classify the real situations they encounter^{5,6}. Those processes transform citizens in identifiable users with right to specific public policies^{4,5}.

The use of categories in the implementation of public policies may have different effects and generate unequal degrees of access when determining varied levels of distribution of merit^{4,6,8}. Categories may also have symbolic effects when reproducing social perverse judgments, stereotypes and prejudices^{5,7,9}.

In this article, it is considered that the TLF are social actors that make cultural and social inserted decisions⁹. Are guided by laws and rules of the State and by the ways they judge the citizens and their necessities. Thus, the TLF may produce and reproduce social inequalities, once they are influenced by the ambients in which they are inserted¹⁰.

That way, the general objective of this article is to comprehend how the TLF, that implement the HIV/Aids policy, operate in political and social categories in institutional contexts of ambiguity in the rules and protocols that should orient their daily work. The specific objective is to analyze the perceptions of the TLF related to the risk behavior and youth categories and its accordance with the HIV/Aids policy.

The HIV/Aids theme is permeated by stigma, blaming of individuals named as 'risk group', moralization of sexuality and discrimination of the LGBTQIA+¹¹ population; which is already sensitive to adults, is even more for the young population².

The structure of the article includes theoretical framework, based on analysis on categories and categorization processes in prevention policies; description of the context of the public policy and methods employed to analyze it; presentation of results, discussions and final considerations.

Categories and categorization processes in prevention policies

The notion of category is mobilized in public policies studies when discussing how socially constructed public images and definitions of problems can affect the citizen's rights^{3,13}. Categories are tools applied to construct groups with right to types and degrees of public policies and services³. Are organizing principles of relations and interactions, inasmuch as they group objects and people around collective attributes, that are highlighted among other possible characteristics^{2,11}.

Although categories are created in designs of public policies, they become concrete when the TLF interact with citizens during the phase of implementation² and transform official abstract categories in concrete decisions⁵. The categorization process, thus, is one of the possible locus of the discretionary practices⁵ and may be described by three main aspects: i) grouping practice and political practice, inasmuch as it classifies, values and establishes eligibility; ii) reducing mechanism of social ambiguities; and iii) social distinctive process, once it promotes inclusion and exclusion and, therefore, distributes rights and sanctions².

In a managerialist perspective, the TLF categorize ways of dealing with the enormous number of users they assist. Their discretion becomes routine a stereotyped, being used in a functional manner, to process users, in a context of limited resources and pressure for results⁵. In a sociological perspective, the

process of categorization results from the cognitive practice of social judgment², and the TLF categorize citizens based on rationalities and judgments^{2,7}.

The TLF mobilize their repertoires – of rules, personal values, social perceptions, professional trajectories, among others – when a decision has to be made^{7,14}. This interpretative activity may generate uncertainties due to the ambiguities, conflicts and dilemmas on what to do, when the TLF confront official guidelines and personal values¹⁵. The TLF classify the users of the services and potentially, act according to the categories they attribute them. This social judgment can inform decisions and actions turned to the citizens, with attention degrees that vary from extraordinary – for those comprehended as ‘good’ citizens – to the minimum help or even rights violation – for those comprehended as ‘bad’ citizens⁷. In preventive policies, this interpretative task is crucial to explain the conceptions of the TLF in their risks perceptions⁵.

In this discussion, the sociological perspective is useful for two motives: enlightens the claims that the categorization processes are not exclusively conditioned by administrative and organizational structures, however reproduce information socially available about citizens, and makes evident how the categorization process is not only anchored in rights, but also in moralities, resulting in separations among those who have right and those who deserve it according to the individual conceptions of the TLF².

The division between deserving and owners of rights, frequently, reflect the operations of social and political categories, being the firsts related to the political-administrative system, and the others, coupled to other systems and social practices¹⁴. Political categories are official, defined in normative texts. Contain the frontiers between citizens included and excluded of the public policies, or their target audience. Social categories represent socially shared notions and knowledges frequently referenced in stereotypes^{5,14}.

Therefore, social categorization processes build attributes considered as common and natural of those categories, and the social ambients establish demands that need to be fulfilled. Will be considered a stranger the one that has a different attribute, as a less desirable subject, dangerous or weak, being reduced to a ruined person. Therefore a stigma is constituted when a person, a group or a community carry social attributes whose value is pejorative, of discredit or negative. Such attribute is considered as a flaw, weakness or discrepancy. Before the difficulty of dealing with the difference, it is constituted an exclusion path, in which the identity incorporates the attribute of negative social value¹⁶.

Researches on the Health field reveal the relations between stigma and illness in its social and political dimensions. The stigma is related to the public policies, the daily practices in the services, the illness, the suffering and the confrontation of its grievances, possibly reducing or complicating the access to the health care services¹⁷.

In the discourses related to the HIV/Aids theme, persist fatalist metaphors, such as of the imminent death, and the association with sexuality. There is still the difficulty of the health care professionals in dealing with the social and psychological dimensions when taking care of this theme, although formally, they have the task of deconstructing those metaphors that contribute for the stigmatization and marginalization of people that live with HIV/Aids¹⁸. That is to say, the TLF end up reproducing inequalities that they should combat¹⁹.

Literature points out the permanence, in the discourse of the health care professionals, of the connection of the LGBTQIA+ identities to the concept of risk group, associated to morally condemned behaviors, as causing diseases and mental illnesses. The possibility of becoming ill is connected to attributes in which the normal subject recognizes the stigmatized²⁰. This aspect is deeply connected to the history of HIV/Aids and to the process of

moral disqualification of seropositive people²¹. The related categories with those were of promiscuous people, prostitutes, criminals or who were with their days counted.

Literature on the social construction of target groups of risk in the frontline of the preventive policies indicates the predominance of social categories, perceptions of normality and stereotypes in the categorization process. The distinction between normal citizens and those in risk is explained by the non-conformity in broader social conventions⁸. Furthermore, the social distance between the TLF and the citizen is an important source of definition on the sense of normality⁶, and a potential (re) production of inequalities, through the stigmatization or the reiteration of stigmas faced by the users of the services. As discussed, the stigma deserves attention in the analysis of the perceptions of the TLF, since it constitutes a crucial theme for the health-disease process, when promoting illness and social and psychological distress in determined social groups²².

HIV prevention policy in Brasil

Considering the organization of the Unified Health System (SUS) in different levels of attention, in Primary Health Care Attention (APS) there is the responsibility for treatment, rehabilitation, prevention and health promotion in the Basic Health Units (UBS), through the generalist services and health care workers of varied categories. The Federal Government has a strong protagonism in the regulation of the APS, that is implemented mainly in the municipalities.

Therefore, the Federal sphere, through the National Policy of STI/Aids, formulates principles, guidelines and strategies, while the State and Municipal spheres can formulate policies on the theme, providing that in line with the national orientation. The HIV/Aids policy – term here employed aiming to

encompass the group of instruments, actions, programs and projects related to the theme HIV/Aids – is implemented by different services and levels of health care, in particular, in primary and secondary health care. The APS concentrates in health promotion and prevention of infirmities, with decentralized and longitudinal services that accompany the citizens in their territory²⁷.

In Brazil, the policy of HIV/Aids was created in the end of the 1980s. However, its focus, its language and the way it should combat the social prejudices have been the subject of disputes²⁸. Until recently, the policies were concentrated in specialized services, which means less focus on the prevention and more on the treatment and care of the target-audiences²⁷. This may explain the difficulty of the services of the APS in focusing in specific target-audiences – once they provide universal and generalist services¹¹, with great demand and many programs of basic attention to be implemented.

The groups that were more affected by the HIV were traditionally stigmatized and with access hampered to the health care services. That way, the HIV/Aids policy and its target-audiences have been historically unseen in the APS services. However, in the last years, new policies were produced in order to give greater prominence to the APS in the treatment of HIV services and more prevention care.

The actual policy has in heart the integrality of the health care and the guarantee of the rights of the people living with HIV. In spite the resistance of many groups, the policy brings new technologies of prevention organized under the strategy named 'combined prevention'^{29,30}, which is rooted in the paradigm of prevention and autonomy of the user. However, several conflicts revolve around this new paradigm, and the responsible services not always have enough information on how to implement it. As a result, are generated ambiguity scenarios³¹ in which the TLF have a high level of discretionarity to interpret the policy and to make decisions³².

A possible explanation for the resistance in building actions from the paradigm of prevention and of the autonomy comes from the perception on youth in the public health field. The public policies are much more directed to the adolescence as a biologic cycle, which enhances the comprehension of phenomena from the theory of instincts and hormones, generating services that aim to control those aspects, and not in the understanding of youth as an emotional, social and political stage of life³³.

An example is the theme of pregnancy in adolescence, frequently treated under traditional approaches based on the notion of 'unwanted pregnancy', as if this could only come from misinformation, and could not result from the desire of the youth to have a child³⁴ or even from violence and abuse. This goes against international organisms, which discuss that 'educative actions shall stimulate the protagonism of youths as holders of autonomy to exert sexuality, to constitute affective relationships and to make decisions in the field of reproduction'¹². Despite that, in the scenario of HIV care for the youth population, are present the stigma and the judgment as persistent phenomena and compromising the prevention.

Material and methods

The article analyzed the implementation of the HIV/AIDS policy in one of the most unequal neighborhoods of the city of São Paulo, Grajaú. Were selected six health care services aiming to make a comparative analysis on how they interpret the policy and the users: two UBS, two services specialized in HIV and two Centers of Psychosocial Attention (Caps). The option for the selection in the same neighborhood was to allow the comparison between the services that receive youths with the same socioeconomic profile and potential users of the same services.

Initially, were selected services specialized in treatment of patients infected by the

HIV. Testing and Advising Centers (CTA) and Specialized Assistance Services (SAE). The CTA provide tests and information on Sexually Transmitted Infections (IST), and the SAE are ambulatory clinics destined to diagnose and to accompany patients infected by the HIV. They are articulated with other services, building care networks in the territories to provide integral health care³⁵. These services are, therefore, specialized in HIV cases, with specific care for this target-audience and with the TLF that receive only this type of user.

Likewise, were selected two UBS with the Family Health Care Strategy team (ESF), services considered as the entrance door of SUS and responsible for primary attention actions in the territories. In the HIV/Aids policy, the UBS shall develop activities of health promotion and prevention of infirmities with the community, however mainly focused on the youth. We shall also provide rapid serological test and referring of the users with positive tests to the SAE³⁰.

Finally, two Caps were included, one of them a specialized service in alcohol and drugs issues and other specific for the children and adolescent population. In the HIV policy, those equipments are responsible for testing and advising users. They shall also refer and articulate the attendance of the cases to the SAE³⁵. We shall highlight that the attendance of the questions related to the IST is a secondary aspect of the action, that is turned to the damage reduction and to the care in mental health.

The inclusion of these three types of services that are responsible for the policies related to the prevention of the HIV, however focused in different responsibilities, allows to observe if and how their TLF apply categories in the classification of the youths, including those that fit the regulations and political categories.

To comprehend the categorization process in different services, were analyzed the political categories available in the regulation, the social categories operated by the TLF and the relation between them. Data was collected from

two sources: from regulations of the policy and from the TLF of the selected services.

Were selected the actual national regulations on HIV prevention policies, and the regulations of the city of São Paulo. The aim was to verify if the municipality adapted or altered the national regulations adopting different political categories. Even if the aim was to analyze specifically the prevention of the HIV among the young population, we may ratify that there is no specific normatives for this target-audience. Were analyzed, thus, the normatives and, whenever possible, was identified what was specific for the youths.

Were interviewed 42 TLF among six services, including doctors, nurses,

psychologists, social workers, nurse technician, community health care agents and occupational therapist. It was a convenience sample, that is to say, were interviewed workers available for the research and whose functions were related to the HIV/Aids policies. The script of the interview contained questions about: knowledge on HIV prevention policies in youth; perceptions on risk behavior of the youth; understanding of prevention and new technologies; and perspectives about young users. The interviews, conducted virtually by the researchers during the working hours of the professionals, were recorded and transcribed fully.

Table 1. Sources and quantity of data collected

Objective	Material	Quantity
To identify categories and risk behaviors	Federal and Municipal normatives	5 Federal normatives 3 Municipal normatives
To identify social categories operated by the frontline professionals	Interviews with frontline professionals in Primary Health Care	22 interviews
To identify perceptions on risk behaviors	Interviews with frontline professionals in the policy of HIV prevention	10 interviews
	Interviews with frontline professionals with mental health equipments	10 interviews

Source: Own elaboration.

The interviews were codified based on this analysis of categories and risk behavior of youths following two stages: The first was inspired in the analysis grounded³⁵ in data in which were codified the categories used to classify the types of young users. The process of codification on risk behavior analyzed the answers to the question 'what do you think is a risk behavior of the youth?'. The answers were codified to comprehend the variations and similarities between each code.

The regulation was analyzed and codified in two manners: were identified the political

categories used to identify the types of users and the official conceptions on risk behavior of the youth.

After the codification of the materials, were analyzed if the categories used by the interviewed were similar to those proposed by the regulation. Thus, were differed the political and social categories and was compared their utilization among the different types of services. Afterwards, the procedure was repeated with 'youth risk behavior', comparing the official categories and related practices related with risk behaviors of youths among types of services analyzed here.

Results

Political and social categories

All the regulations analyzed define that the HIV prevention policy shall be directed to two groups: 'target group' (gay men, Men who have Sex with Men – HSH, drug users, sex professionals and transgender people) and the 'priority population' (black population, people living in the streets, indigenous population and youth population), defined as such in the regulations.

The first group is composed by highly specific political categories, whilst the second is highly general and embraces the majority of the Brazilian population. The first group is justified by the higher tax of infection among people of those population segments. The second group is defined among those who are also affected disproportionately, considered all the population. However, differently from the first group, their infection taxes are explained not by their behavior, but by the social local dynamics. According to the rules, because they already have socioeconomic vulnerabilities, they are considered more susceptible to the infection and shall be prioritized in the policy. We shall ratify that the youth population is in this subgroup and it is defined according

to its vulnerability. Nevertheless, this does not mean that there are no youths holding the characteristics that are presented in the target-audience, that is to say, the youths fit in both political categories.

Were identified two findings in the analysis of the regulations. The first is that the political categories used are ambiguous, especially those related to the priority groups. While including the majority of the Brazilian population, they create spaces for interpretations on who shall be prioritized. This enhances the identification that the youths can be placed in all the categories. The second is that, when justifying the political categories of the target-groups on infection taxes, the policies reinforce the prejudice. Therefore, the political categories, as they were created, are not capable of combating social categories and may also strengthen them. This way, it became important to analyze how the TLF operate those and other categories.

When analyzing the categories operated by the TLF, were found three groups of categories: those based on behaviors; those based on socioeconomic profile; and those based on gender and sexuality. Some of those categories are inspired by political categories, and others are not. The *table 2* describes the categories found in the interviews.

Table 2. Categories operated by frontline workers and types of services

Categories	Types of Categories	APS	HIV	Mental Health	Total
Behavior categories					
Drug use	Political	13 (22)	2 (10)	10 (10)	25 (42)
Sexual behavior	Political	11 (22)	4 (10)	5 (10)	20 (42)
Social behavior	Social	21 (22)	6 (10)	7 (10)	34 (42)
Socioeconomic categories					
Family dynamics	Social	9 (22)	2 (10)	5 (10)	16 (42)
Social class and income	Political	7 (22)	9 (10)	8 (10)	24 (42)
Profession	Political	2 (22)	5 (10)	1 (10)	8 (42)
Gender and sexuality categories					
Woman	Political	20 (22)	0 (10)	3 (10)	23(42)
Men	Political	8 (22)	5 (10)	4 (10)	17 (42)
LGBTQIA+	Political	1 (22)	7 (10)	3 (10)	11 (42)
HSH	Political	0 (22)	8 (10)	0 (10)	8 (42)
Black/white	Political	0 (22)	4 (10)	3 (10)	7 (42)
Heterosexual	Social	0 (22)	3 (10)	2 (10)	5 (42)

Source: Own elaboration.

The analysis suggests that the TLF use political and social categories when classifying the users. When comparing services, those of the primary care tend to operate more social categories than the others, specially in relation to the behavior category²¹. The TLF of the specialized service in HIV use more political categories – mainly those based on gender and sexuality. Thus, they tend to categorize the youths aligned with the political regulations. Finally, the TLF of the psychosocial health care services tend to merge political and social categories, specially those directly connected to the expertise of the service, such as drug use and socioeconomic characteristics.

The data also show the high prevalence of the categorization of behavior in comparison with other types of categories. Considering the regulations and the evidences on illness, it is expected that the TLF mobilize categories associated to the use of drugs and to sexual behavior. Yet, 34 of them mentioned categories on behaviors that are not in the policies design: those on sociability. For the TLF, the youths that go to parties or social activities have a higher chance of being infected.

The data also display that the social class matters in the categorization of the youths: 24 of the interviewed, in different types of services, believed that the youth of a lower social class and with lower level of schooling have a higher chance of being infected.

Finally, it was identified the differential use of categories on gender. Whilst the TLF of the APS and of the mental health equipments think of generic youths, with no specific profiles associated to the regulations (such as woman and man), the TLF of the HIV policy think about the gender categories proposed by the policies as target-groups, such as LGBTQIA+ and HSH.

Perceptions on risk behavior

Were analyzed also the perceptions of the TLF on the called 'risk behaviors' of youths. This concept became central in the Brazilian politics on HIV prevention since 2010 when considering that the political interventions shall be concentrated in the behavior of the youths as a way of preventing risk situations. Those interventions are based on offering

information to allow the youths to identify risk situations and behaviors that shall be avoided. As proposed by the regulations, those interventions are related to the quotidian practices, that involve or not the aspects related to the

sexual practices, to the use of alcohol and other drugs or to other behavior that imply risk of infection by the virus²². Three different sources of risk behavior are identified in the regulations and described in the *table 3*.

Table 3. Official notions on risk behavior

Types of risk behavior	Composition	Examples
Conduct	Sexuality	Repetition of anal and/or vaginal sexual practices with penetration with no use of preservative; unprotected sexual relation; sexual promiscuity; sex parties.
	Drug use	People who make problematic or sporadic use of alcohol and other drugs; use of injectable drugs.
Work	Profession	Sex professionals; exchanging sex for money contexts, drugs, housing etc.

Source: Own elaboration.

When analyzing the perceptions of the interviewed on risk behaviors, were found three

types: associated to the conduct; associated to the information and associated to violence (*table 4*).

Table 4. Risk behavior for interviewed

Types of risk behavior	APS	HIV	Mental Health
Conduct	20 (22)	8 (10)	10 (10)
Information	3 (22)	1 (10)	4 (10)
Violence	1 (22)	0 (10)	2 (10)

Source: Own elaboration.

The data on risk behavior suggest that the majority of the TFL associates the risk to the conduct, and not to the work or to the violence, according proposed by the regulations. In relation to the information, eight interviewed consider that this is associated to the risk behavior. They believe that the lack of information or the lack of trust on the official information may increase the risk of infection by the HIV, specially among youths. The distrust performs an important role in explaining

youths' behavior. The TLF mentioned that, many times, they perceive that the youths have information, but decide not to prevent anyway, as if nothing would happen to them.

Finally, the perceptions on violence as a risk behavior are similar to what is proposed by the regulations. Only three of the interviewed mentioned that, and when they did it, generally associated violence to another behavior, such as the use of drugs and alcohol, that make the youths more vulnerable.

Table 5 presents the different perceptions of the interviewed on the conduct as a risk behavior. In the APS, the majority suggests that sociability, sexuality and the use of drugs are risky. The idea that the parties are risk

factors is not mentioned in the regulations. However, for the interviewed of the HIV services and Psychosocial, the sociability was not considered risk, being the risk associated to the sexuality and drug use.

Table 5. Types of conducts of risk behavior

	APS	HIV	Mental Health
Sociability (parties)	12 (20)	0 (8)	0 (10)
Sexuality	17 (20)	7 (8)	9 (10)
Drug use	14 (20)	1 (8)	5 (10)

Source: Own elaboration.

The TLF also interpret differently the meaning of sexual risk. In the specialized services (HIV and mental health), the risk related to the sexuality was associated to technical and political aspects, such as being part of vulnerable population and the necessity of using preservatives and other prevention technologies. In the APS, the workers approached the sexuality issue from the moral point of view, discussing the number of partners and the sexual orientation of the users.

The findings pointed out important differences between the services, specially relating to the frequency of the use of each one of the types of categories: Whilst, in the specialized services, there is a higher use of political categories to describe the target-groups, the social categories predominate in the primary care services and, in some extent, in the psychosocial attention services.

Discussion

The political categories related to the HIV are permeated by notions full of stereotypes and stigmas since the 1980s as it is demonstrated in literature^{11,28}. That means that the political

categories may, in practice, reinforce the social categories^{3,10}. A latent social category can be translated in a political category as a result of power negotiations, influence of favored groups^{3,10}. Social categories and normality perceptions can legitimate tools and political categories inasmuch as they overlap and change mutually⁷.

The main implication is that, even in an universal health care system, as the Brazilian, the policies may reproduce inequalities during the implementation of policies inasmuch as their political categories reinforce the social based on prejudice and exclusion.

This analysis suggests that the prevention policy of HIV consolidates some categories of target or priority with vague and ambiguous content, with black people or youths, that include a great number of people, leaving to the TLF the responsibility to choose who are the true priority targets. As already pointed out by Raaphorst e Groeneveld¹⁵, this creates spaces for the operation of broader social perceptions and becomes a source of interpretative uncertainties. Therefore, the data of this study reinforce the statements made by Lotta e Costa¹⁰ that the use of social categories by the TLF commonly exceeds the use of political

categories, creating a potential scenario for the reproduction of inequalities.

When using social categories based on judgments on social and sexual behavior, the TLF introduce political issues related to the non-compliance of the users with wider social conventions, including notions of what they understand as 'deviant sexuality' or on the use of drugs. Complement the political definition of target-group with shared social impressions on who is more vulnerable or exposed to the virus, what may enhance prejudices. As an example, when categorizing the user to describe the typical youth in risk, some interviewed mentioned criteria such as 'party-ing' or characteristics such as 'immature' or 'negligent'. When talking about sexuality, few mentioned the number of partners or casual sex, instead of prevention issues or the use of preservative, as envisioned by the policy. Those evidences meet what is already highlighted by the literature on stigma and HIV that the health care professionals still associate morally condemnable behaviors to Aids²⁰.

Besides the use of stereotypes, there is an important difference among the workers in the analyzed services that mark the use of the categories: the quantity of official policies and guidelines with which they have to deal with in their daily work. In the services turned to the prevention and to the care of the IST, the preventive actions are directed specifically to the public that seeks them. In contrast, the workers of the primary care attention are, at the same time, dealing with preventive actions against hypertension, diabetes, arboviruses and other issues under the competence of the APS.

Yet in the other services of psychosocial attention, there is a pre-selected public: people with mental health issues. However, the policy of HIV prevention is not a quotidian part of their routines, crossing laterally the attendances and the issues treated. The political categories become 'diluted' in primary care services in comparison with those that focus on IST, and appear in a secondary manner

in the psychosocial care services. Therefore, the exercise of discretionarity has different effects on the categorization process and on the categories mobilized by the workers.

Regarding the youth's risk behavior, the specialized services of IST? Aids frequently pointed to the sexuality whilst the specialized equipments of mental health considered the risk of drug use, and the workers of the basic care mentioned conducts, some included in the policy and others not. This fact may be related to the target-group of intervention of each service: In the services of IST/Aids, the workers deal with youths that seek for prevention or treatment of IST, and in the mental health services, the TLF deal with youths with issues connected to the mental health, including drug abuse. That means that, in services turned to the IST, the public for prevention actions is concrete, in the sense that the workers do not have to choose who to advise or offer a test or prevention information on HIV. This is the center of their work, and each user is submitted to those interventions.

In the services of psychosocial attention, the public is more 'filtered' than in the primary care, however, for not being centered in the HIV prevention, the professionals also will have a certain degree of choice of the users to whom they will propose the prevention of the HIV. Finally, the workers of the services of primary care are promoting the prevention among potential publics, and have to choose who needs information and service on each type of policy.

The necessity to select a target-group, associated to the political categories already marked by ambiguities and the consolidation of social categories of sexual behavior and race, for an example, favors the process of categorization based on social perceptions. Once the TLF need to choose based on their common knowledge and perspectives, the use of social categories can be (and probably will be) constructed in judgments and stereotypes. The connections made between the perception on the potential beneficiaries and

their families or sociability spaces attended by the youths demonstrate how the works operate the process of categorization, relating poverty and vulnerability with the exposure to the virus.

As already highlighted by the literature^{3,10}, in a context of great inequalities, the study of the (re)production of the inequality in the implementation of social policies is, in part, around the own policy design. Crystallizes social categories immersed in stereotypes and imprecisions. According to the evidenced by Bastos¹⁸ e Cazeiro et al.²², such characteristics result from the trajectory of conflict of the HIV/Aids policy in the social and political debates. Following the epidemic of the 1980s, the HIV was a shocking theme, permeated by controversies around morality. After years of campaigns and conquests by the social movements, the actual institutional scenario is of protection and recognition of rights of the people infected by the HIV. In the health care system, this translates into treatment services, when the infection has already happened, and also in prevention policies.

It is undeniable that the Brazilian health care system has specific policies of protection and reduction of inequalities for determined groups and diseases, such the policy of HIV/Aids. However, the potential of reproduction of inequalities is a legacy of the conflict and of the ambiguities that mark its formulation. When it is related to the TLF, they may reproduce the inequalities already presented in the formulation of policies. Besides that, considering the ambiguity of the political categories, they can also introduce additional social categories based on judgments and prejudices that enhance inequalities. This is yet more evident when comparing services of primary care and specialized in the actions of prevention of the HIV with youths. The political categories are more used among the specialized services than among those with primary care approaches, creating spaces for using even more social categories.

Final considerations: the mutual influence of the political and social categories

This article analyzed the processes of categorization of the youths developed in the implementation of the prevention policy for the HIV in a vulnerable neighborhood of the city of São Paulo, aiming to observe specificities of three different types of services: APS, services specialized in HIV and mental health services. The objective was to understand how the TLF operate social and political categories in front of an institutional scenario of ambiguities and conflicts in the rules and guidelines that orient their quotidian work.

The results suggest that the social and political categories have mutual influence. In the first place, despite the changes in the legislation on the theme and the increasing debates on the construction of less stigmatizing normatives, the political categories are still legitimated through social perceptions of normality and risk, specially when dealing with the priority population, such as black people, for an example. That means that the reproduction of stereotypes starts in the normative, but can be broadened in the implementation of the policies.

This happens due to the ambiguity of the standards that delegate to the services the choice of who will be the true target-group. There is a special difference between the services: the specialized services deal with concrete users, whilst those of the primary care, with potential users; and the TLF need to identify who is more vulnerable to the infection by the HIV. This fact influences the way the TLF use the categories in their work, once the specialized services in IST are more familiar with the political categories, and the APS services and the mental health services have to complement their knowledge with shared social notions to find the target-group.

In this regard, the social categories operate frequently in the context of the implementation of policies, enhancing the stigmas and judgments when selecting the groups more vulnerable to the risks. In practice, this context may reinforce the stigmas with some youths, such as black people and poor people, single mothers and the LGBTQIA+ community. Analysis of previous studies suggest that the stigma constitutes a central theme for the health-disease process, since it still promotes illness and psychological and social suffering of determined social groups, since prejudice and stigmatization can be more lethal than the virus itself²².

Collaborators

Costa MIS (0000-0002-9117-5089)* contributed for the data collection, analysis, writing and final review of the text. Lotta G (0000-0003-2801-1628)*, Salatino LC (0000-0001-7906-1954)* and Miranda JR (0000-0002-0147-5548)* contributed for the data collection, analysis, writing and final review of the text. Agrela E (0000-0002-5335-5417)* contributed for the writing and final review of the text. Franceschini MC (0000-0003-3072-5160)* contributed for the conception of the work and the critical review of the manuscript. Akerman M (0000-0003-1522-8000)* contributed for the review and definitive approval of the version to be published. ■

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