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Portugal – Reducing stigma and increasing knowledge and confidence amongst primary healthcare workers to increase testing: Portugal

What was the issue?

In 2013 the Portuguese Ministry of Health adopted a policy to expand HIV screening at primary care sets (PCS), the general healthcare services used by most Portuguese people. It announced that 40,000 rapid tests would be made available for HIV testing in PCS settings. However, in March 2015 the Health Directorate on HIV (DGS) announced that only 3,300 tests had so far been done through this scheme. In total, the uptake was 3,000 in 2014 and only 2,138, in 2015. This increased to 3.980 in 2016.

Why was change needed?

Evidence suggested that there was widespread ignorance of the existence and content of the DGS testing and testing policies at ground level. Awareness of the national policy was a prerequisite for issuing and implementing the local/internal standard testing procedures needed to increase test offers and uptake within individual primary care units (ACES).

An initial scoping questionnaire developed by Project Respect as part of OptTEST showed that 57% of nurses and 44% of doctors in ACES were not aware of the testing protocol and only 21% reported that their operational unit had standard procedures for HIV screening.

What/who were the barriers to change?

The health professionals identified some overarching obstacles about sharing and accessing information and documents, including the protocol. They were:

- Poor computer facilities and breakdowns in access to central systems;
- Lack of communications systems other than emails;
- Lack of appropriate content on their regional health administration site;
- A non-user-friendly repository of DGS documents, not classified or indexed by subject or descriptor, but by a bureaucratic classification
- Financial and budgetary restrictions

However, there was both national and local support for an improvement in testing rates and understanding of HIV.

How long did change take and who was involved?

SER+ worked with the Regional Health Administration of the Lisbon and Tagus Valley area and the National AIDS Plan/General Directorate of Health. This began in January 2016 and is ongoing in 2017.

How was change made?

Pilot research (interviews, questionnaire) was done in 2016 with three primary care groups, according to expressions of interest. In total, 167 questionnaires were returned. This identified the main obstacles – knowledge, attitudes, awareness, information, facilities and internal organisation. Tailored action plans for each ACES were developed in early 2017 including:

- detailed presentation of the results to the local coordinators at each ACES
- A focal group at each ACES to design the content of local interventions together with the project team

These local interventions included tailored training events, open either to designated staff in key units or to all those interested; widening access to other stakeholders in one municipality that became a “Fast Track City” for HIV; a training module for roll-out with all staff; a “training the trainers” programme to support young interns to replicate these courses in the future.

In two settings where training has already been implemented and evaluated via questionnaire, knowledge and attitudes about HIV amongst staff improved from 71% and 74% positive respectively to 99% positive responses post-intervention.

Are there any ongoing issues?

Given the short-term announcement and the holiday period it was offered in, attendance at the initial training courses was small compared with the number of health professionals of both ACES . This will be dealt with by replicating the training after the summer holidays and with more than one round to cover the maximum number of health professionals.

The longstanding problems of financial and logistical resources, particularly related to IT and web systems design, need to be addressed at a higher level than the PCS. The highly-centralized decision process requires action from the central administration of the Health system and the shared systems of the Health Ministry and the Health General Directorate, to allow for a useful and user friendly search tool for PCS to use and identify new protocols and initiatives.

What lessons have been learnt?

It is possible, through working together, for government and clinical systems to harness the lower levels of bureaucracy and training expertise of NGOs to provide a relatively swift response to identified problems. While some systemic and bureaucratic barriers are more difficult to tackle, those caused by outdated attitudes or limited knowledge can be improved with relative ease if the will is there to do so.