ISSN: 2832-7942
DOI: 10.33552/APHE.2025.03.000553
Annals of Public Health & Epidemiology
Iris Publishers

Research Article

Testing in Mass and Vulnerability Social: The Paper of Policies Public Node Access to the Diagnosis of Infections Sexually Transmissible in Community's Peripheral

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Received Date: August 07, 2025

Published Date: September 25, 2025

Abstract

Mass testing for sexually transmitted infections (STIs) is a critical strategy for controlling these diseases, especially in socially vulnerable contexts. This study critically examines the effectiveness of public policies related to STI testing in urban peripheral communities in Brazil, considering structural inequalities, institutional barriers, and social dynamics that limit access to diagnosis. Through a qualitative approach, the research analyzes official documents, scientific literature, and community experiences to demonstrate that, despite the universality and equity principles of Brazil's Unified Health System (SUS), operational gaps, institutional racism, symbolic discrimination, and a lack of territorial planning persist. The study highlights the strategic role of multiprofessional teams and defends mass testing as a tool for health justice. It concludes that when implemented with cultural sensitivity, community engagement, and intersectoral collaboration, mass testing strengthens comprehensive care and reduces the epidemiological invisibility of marginalized populations. Sustainable, inclusive, and anti-discriminatory policies are essential to effectively address STIs in Brazil's urban peripheries.

Keywords: Mass testing; sexually transmitted infections; social vulnerability; public policies; urban peripheries; institutional racism

Introduction

The persistence of sexually transmitted infections (STIs) in highly vulnerable territories social reflects the intertwining of determinants social from the health and the insufficiency of universalist public policies. The prevalence of these conditions is exacerbated in communities peripheral urban, where the precariousness of infrastructure and underfunding of the Unified Health System (SUS) limit access to essential diagnostic strategies, such as mass testing. According to Bispo Júnior and Santos [1,2], these regions concentrate intersectional effects of inequality, which compromise the fundamental right to health and reveal structural flaws in implementation of policies public territorialized.

THE concept of vulnerability in health and fundamental to understand to the disparities in diagnosis of STIs. This concept transcends the dimension biomedical and covers factors such as race, gender, class and territory. THE absence of coverage adequate of actions testing fast in areas peripheral and illustrative from the

neglect historical faced for these populations. Studies demonstrate what to the campaigns of testing, same when available, no reach the completeness nor respect the particularity cultural of the territories [3], highlighting one performance fragmented of State.

The approach to STIs requires a robust articulation between epidemiological surveillance, care basic and promotion from the equity. THE testing in mass and one strategy essential for containing transmission, but its effectiveness depends on its integration with intersectoral policies. Marino, Lima and Mateo [4] point out that community experiences of testing during the pandemic of COVID-19 evidenced the need to expand the State's role beyond the biomedical logic, incorporating local knowledge and strategies of mapping participatory. AND important highlight what the deficit of access to the diagnosis in communities' peripheral areas is also anchored in discriminatory institutional practices. The territorial and racial selectivity of public health actions restricts systematic testing to certain groups, promoting statistical invisibility. Santos and Silva [5] argue that structural racism permeates resource allocation and prioritization criteria. of territories, impacting directly the response state-owned to the STIs in the peripheries. Multidisciplinary work emerges as a strategic axis to reverse these asymmetries. Teams composed of community health workers, nurses, and psychologists and assistants social they are more effective in the construction of links territorial and in addressing cultural and structural barriers to testing. Vasconcelos et al. [6] highlight what the Strategy Health from the Family, when good structured, and able to enhance the coverage diagnostic of STIs, especially to the to work with focus in the dynamic's territorial and affective of peripheries.

In that context, the formulation and execution of policies public must if support in a conception of health collective committed with the justice social. THE universality of SUS needs to be realized put quite of actions focused and territorially sensitive, such as testing campaigns with an educational approach, ethical reception and respect for diversity. To Nassar [7], the recognition of peripheries as active subjects and not merely recipients of care is imperative for effective public health emancipatory.

Contextualization of Problem

THE emergency of infections sexually transmissible (STIs) as problem of public health in Brazil reflects not only the biological complexity of these diseases, but above all the persistence of iniquities social and sanitary what permeate the access to the diagnosis and treatment. Data recent indicate growth alarming us cases of acquired syphilis, syphilis in pregnant women and congenital syphilis, in addition to the sustained prevalence of HIV/AIDS and viral hepatitis in determined vulnerable populations [8]. This scenario this intrinsically related the low coverage from the attention basic in peripheral areas and the absence of strategies effective of surveillance active and testing in mass, what perpetuates cycles of underreporting and dissemination silent of STIs [6].

Historically marginalized populations among them, black people, indigenous people, LGBTQIA+ people, users of drugs and residents of community's peripheral present greater load of illness put STIs, result direct of processes social structuring as the racism institutional, the inequality territorial and the violence structural [5]. THE failure of actions of testing systematic in these communities reveals a failure of State in ensure the principle from the equity predicted node System Single of Health (SUS). In addition, from that, the absence of approach intersectional in the policies public of health contributes to the invisibility epidemiological of these groups, making it difficult the formulation of adequate responses [7].

AND important consider what your determinants social from the health operate as filters access to diagnostic services. Factors such as education, income, geographic location, and stigmatization are determining factors in the lower demand and lower supply of STI testing in peripheral territories. Studies show that territorial distribution of the services of health and unequal, the what if translates in one distancing physical and symbolic between your services and to the needs real from the population vulnerable [1]. This disconnects between policies and local realities demand a reorientation of model assistance with focus in the equity and in the territorial accountability.

Although national guidelines for combating STIs propose broad prevention, diagnosis, and treatment actions, the implementation of these actions faces operational barriers. and policies in contexts marked for the exclusion. To the campaign's nationals of testing, they are often centralized in areas urban central and lack capillarity in regions of bigger vulnerability social. In that sense, as Soares and Pontes [3] highlight, it is urgent to rethink the mechanisms for implementing policies public of health sexual and reproductive, of form the to guarantee your adequacy to diverse territorial contexts, promoting universal and dignified access to early diagnosis.

Inequalities in Health and Determinants Social

To the inequalities in health result of one complex set of determinants social that mold you risk, accesses and outcomes related to the illnesses, especially in contexts of social vulnerability. In Brazil, such inequalities are historically associated with income concentration, precarious housing, low education levels, and lack of basic sanitation, factors that are unevenly distributed across territories. and groups population. Those determinants, to the interact, create environments propitious the dissemination of infections sexually transmissible (STIs), particularly among populations peripheral urban [1]. The relationship between social determinants and sexually transmitted infections is evidenced by greater exposure to risk contexts, such as sexual violence, precarious informal work, lack of links to health services, and low ability to negotiate condom use. Vulnerable populations present minor probability of access services of testing and treatment of STIs, many times put barriers logistics, stigmatization institutional or discrimination racial and gender [3]. Such elements aggravate underreporting and perpetuate the invisibility epidemiological of groups marginalized.

THE perspective intersectional and essential to understand as different forms of oppression as racism, sexism, LGBTphobia and

classism interact in the production of inequalities in health. In special, women black, people trans and young people peripherals are between you more impacted by STIs, no just put factors behavioral, but by fragility of networks of Careful and for the absence of policies public specific and integrated. As discuss Santos and Silva [5], the neglect institutional before of these populations reveals one face structural from the inequality sanitary node country. The traditional biomedical model, centered on individual accountability, often ignore you conditions social of STIs and, put consequence, contributes to the ineffectiveness of actions preventive and of diagnosis. To reverse that painting, it is essential that health planning considers social determinants as elements structuring of policies of confrontation to the STIs, incorporating territorial strategies, participatory and multidisciplinary. Vasconcelos and al. [6] reinforce what the expansion of access he must be ally to the strengthening from the attention basic, with focus in the territories socially made vulnerable.

Discrimination Structural and Racism Institutional

THE understanding of inequalities in health requires the recognition of what the racism is not an episodic phenomenon, but a structural one, that is, it is rooted in the ways of organization social, economic and institutional. Node Brazil, the logic of distribution unequal of services of health, as the testing of infections sexually transmissible (STIs), reveals the persistence of standards historical of exclusion racial and territorial. THE black population, mostly resident in areas peripheral, faces larger barriers access to diagnostic tests due to the location of public equipment, treatment discriminatory us services and the scarcity of policies focused [5].

Institutional racism manifests itself when organizational norms, practices and conduct result in in the exclusion systematic of determined groups racial of the resources social. In the health field, this exclusion is evident in the scarce presence of active testing strategies in racialized and impoverished territories. According to Soares and Pontes [3], the absence of actions continuous and territorialized of diagnosis in black communities urban contributes to the deepening of iniquities and to the epidemiological underreporting of STIs, making it difficult interventions based in evidence. In addition, from the dimension territorial, the racialization of access to the Careful also if reveals in the form as you professionals of health interact with users' blacks and indigenous people.

Barriers symbolic, as the prejudice implicit and the denial from the listening qualified, limit adherence to strategies of prevention and reduce trust in public services. Study of Bishop Junior and Santos [1] points what the lack of training anti-racist in institutions of health contributes to the perpetuation of practices what reinforce stigmas and reproduce the logic of exclusion systemic. Overcome these inequalities requires the strengthening of policies public anti-racists and the recognition of paper of State in the production of injustices sanitary. Vasconcelos et al. [6] argue that the universality of health services can only be achieved when actions are designed based on the territorial and cultural specificities of racialized populations. In this sense, ensuring equitable access to STI testing involves reviewing protocols, training teams in an intersectional approach, and decentralizing you resources of form proportional to the need's social.

Testing in Mass as Strategy of Health Public

Mass testing is one of the most effective tools in containing epidemics transmissible, including the infections sexually transmissible (STIs), by allowing the identification early of cases asymptomatic, the interruption of chains transmission and the direction of policies of treatment and prevention. Node case of STIs, many of which evolve silently in the early stages, the lack of systematic testing compromises timely diagnosis and increases the risk of complications, such as infertility, transmission vertical and coinfections [8]. Like this, the testing in mass must be understood as a structuring strategy of health public, not just a one-off action.

By being included in the scope of epidemiological surveillance, mass testing increases capacity of system of health of monitor tendencies and map with bigger precision the burden of STIs in specific territories. In peripheral communities, where there is greater social vulnerability and less access to laboratory testing, this strategy can promote diagnostic equity, as long as it is combined with active search and coordination actions. community. Studies demonstrate what interventions with testing fast and decentralized achieve better results when community agents are involved and organizations places [6]. Node however, the effectiveness from the testing in mass depends of your integration with social communication strategies, ethical embracement, and ongoing clinical monitoring. Fragmented initiatives focused solely on data collection tend to fail to promote of Careful integral. Soares and Bridges [3] warn what campaigns what do not consider the context socio-territorial of populations tested they can reinforce stigmas and resistances. Put that, and fundamental what to the actions of testing be aligned to the principles of SUS, especially you from the universality, equity and completeness.

During the pandemic of COVID-19, the importance from the testing in mass he was widely debated, and various experiences of testing population evidenced your ability to guide public policies based on evidence. Although in a different context, these experiences also offered lessons valuable to the confrontation of STIs: the importance of decentralization, adequate logistics and data transparency [4]. Transfer these learnings to the field of sexually transmitted infections transmissible he can qualify the response of State front to the historical inequalities in access to diagnosis.

Other aspect relevant and the cost-effectiveness from the testing in wide scale. Diagnose STIs of form early and massive reduces you costs hospitals associates to the late complications and avoid new cases, mainly in populations with high rate of exhibition and low coverage of attention basic. Second Bishop Junior and Santos [1], you cost with hospitalizations put syphilis congenital or infections opportunists put HIV they are significantly larger of what your investments necessary in strategies preventive measures with base

in testing. Thus, the economic argument reinforces the viability of implementing sustainable testing programs. Finally, the testing in mass he must to be understood as one device political and technical of guarantee of right the health. To the universalize the access to the diagnosis, the State complies your duty constitutional and reduces the invisibility epidemiological of neglected populations. Node however, as highlight Santos and Silva [5], to what such strategy has effectiveness, and necessary break up with logics institutional exclusionary and ensure that testing is accompanied by educational, therapeutic and social actions, anchored in the intersectorality and in the justice sanitary.

Policies Public in Health: Advances and Limits

To the policies public facing to the confrontation of infections sexually transmissible (STIs) node Brazil they were historically molded put contexts of crisis, as the epidemic of HIV/AIDS in the decades of 1980 and 1990. THE country it won recognition International for adopting strategies focused on prevention, free testing and distribution of antiretrovirals through the Unified Health System (SUS), configuring an innovative model of response state-owned [8]. Nonetheless, although you have there was normative advances, the practical effects of these policies on urban peripheries remain limited before of inequalities structural persistent. The National Guidelines for Combined Prevention of STIs, launched in the 2010s, expanded the traditional approach by incorporating biomedical and behavioural methods allies the testing periodic. However, studies demonstrate what These guidelines have had little impact on peripheral territories, where health services face overload, staff turnover, and a lack of community engagement [6]. In these contexts, preventive and testing actions are often discontinued or replaced by sporadic campaigns without continuity. territorial or intersectorality.

The strategies based in the Primary Care, such as Strategy Health from the Family (ESF), presented transformative potential due to their proximity to the territory and possibility of approach community. Node however, according to highlight Santos and Silva [5], its effectiveness was hampered by budget cuts, low population coverage in slums and absence of specific focus on populations made vulnerable to STIs. The absence of a national policy aimed exclusively at peripheral populations contributes to these locations being treated as "low priority areas", same before of high prevalence of STIs. Initiatives punctual of expansion from the testing, as the project "Alive Better Knowing", implemented for the Ministry from the Health with support of organizations from the society civil, showed results promising. That project, back mainly to vulnerable populations (as young people, population black and LGBTQIA+), offered testing fast with approach humanized in places no conventional, as parties, bars and communities [3]. Yet like this, your limitation temporal and dependence of restricted local partnerships made it difficult to institutionalize action within the scope of permanent policy health.

THE mapping of good practices in municipalities as They are Paul and Savior evidence what policies decentralized with focus in the testing community, linked the strategies harm reduction and multidisciplinary monitoring tend to be more effective [1]. However, such experiences are still exceptions and depend on local political will, not constituting a national standard. That asymmetry territorial compromises the completeness from the response the Epidemic of STIs in the country. In addition, from that, the fragmentation institutional between you levels federal, state and Municipal governance hinders the consolidation of lasting policies. The lack of clear guidelines for joint action between health, education, and social assistance limits the scope of intersectoral actions. Second Marino, File and Mateo [4], policies of confrontation to the ISTs need to consider the peripheral urban context as a living space, crossed by violence, informality and collective agencies, requiring a territorialized and participatory approach.

Other limit important reside in the scarcity of data disaggregated put race, territory and identity of gender us systems of information in health. That generates one statistical invisibility of the most vulnerable populations and compromises the formulation of policies based in evidence. THE absence of indicators specific makes it difficult the monitoring of actions and mask to the iniquity's node access the testing and to the treatment, reinforcing inequalities preexisting [5]. Put end, and necessary to recognize what to the policies public of health facing to the STIs still operate under biomedical logic and little dialogic. Active listening to communities, valuing of knowledge popular and the investment in actions educational continuous are often overlooked strategies. As claim Nassar et al. [7], sustainable policies depend from the articulation between State and society civil organized, with emphasis in the co-responsibility collective and in the resignification of Careful in health.

Vulnerability Social and Barriers to the Diagnosis

Access to early diagnosis of sexually transmitted infections (STIs) is a fundamental health right, but it faces serious obstacles for populations living in peripheral urban areas. The precariousness of transportation systems public, the long distance until to the units of health and the absence of schedules operating compatible with the reality of work informal make it difficult the search active by services of testing [6]. In many cases, the displacement to one center of diagnosis requires expenses financial and time what these populations can't dispense, the what contributes to the permanence of diagnosis late and the expansion of transmission chains. THE stigma social also constitutes one barrier symbolic significant to the access to STI diagnosis, especially in communities with strong conservative moral and religious norms. The historical association between STIs, promiscuity, and crime contribute to individuals avoid seek testing for fear of judgment, discrimination or exhibition of your guidance sexual, identity of gender or practices sexual [5]. That dimension subjective from the vulnerability, although often made invisible in programs health, and decisive for low adherence to actions of testing, above all between young people, men and people LGBTQIA+. The lack of information adequate and accessible on STIs and their diagnostic methods still and one reality worrying in the peripheries urban Brazilians. Lots of prevention campaigns are focused on mass communication channels, without considering the linguistic, cultural, and educational specificities of the

territories. As Soares points out, and Bridges (2021), the absence of strategies of education popular in health reduces the perception of risk and weakens the bond between users and your services, perpetuating a cycle of misinformation and invisibility. Testing, in these cases, ceases to be understood as one Careful preventive and raisin the to be associated to the illness or to punishment moral. Furthermore, there is evidence that the very functioning of health services represents a barrier to access. The lack of trained professionals, staff turnover, and the unpreparedness of units to deal with vulnerable populations directly affect the quality of care [1]. In many cases, reports of negative experiences such as neglect, embarrassment, or withheld information discourage people from returning to the system of health, affecting the continuity of Careful and the trust institutional. These factors highlight the need for public policies that address the multiple dimensions of exclusion in access to diagnosis.

The Performance from the Team Multiprofessional

equitable access the testing of infections sexually transmissible (STIs), especially in vulnerable populations. Nursing, medical, social service professionals, from the psychology and from the education in health act of manner integrated in the construction of expanded and resolute care. According to Cardoso et al. [9], the shared approach between different knowledge favors the binding of the users to the services, expands the listening qualified and allows the identification early of demands hidden, as the fear from the testing or the experience of stigmas social.

Nursing plays a strategic role in the line of front of testing, especially in the units of attention primary and in the services of specialized attention. These non- professionals just perform you tests fast, but also welcome, guide and accompany the patients us flows of Careful subsequent. Of agreement with Almeida and et al. [10], the performance from the nursing in education in health and node advice pre- and post-testing is fundamental to strengthen the autonomy of user and reduce barriers emotional to the diagnosis, above all in contexts of high vulnerability. Social service contributes directly to mediation between the subjects and your social rights, focusing on overcoming inequalities in access to health services. Professionals in this field work in conjunction with public housing, welfare, and education policies, promoting expanded care and addressing vulnerabilities. social what make it difficult the accession to the diagnosis and treatment of STIs. According to Coast and Rock [11,12], the social worker operates as agent political in the territory, connecting strategies of Careful and inclusion social with to the needs concrete of the population peripheral.

Put your time, the psychology he has paper decisive in the listening of subjectivities what permeate the process of testing, as the fear of result, the impact emotional of diagnosis and the confrontation of stigma. THE performance psychological favors the humanization of Careful and strengthens adherence to therapeutic monitoring. Silva et al. [13] point out that psychosocial practices integrated into the testing routine increase the capacity of services to respond to the multiple dimensions of vulnerability, contributing to the reception ethical and the Careful continued.

Objectives of Study

This study he has as objective general to analyze of form criticism the effectiveness of public policies aimed at testing for sexually transmitted infections (STIs) in peripheral urban communities, in light of the structural inequalities, institutional barriers, and social dynamics that affect access to diagnosis. The premise is that mass testing, although recognized as a fundamental strategy for epidemiological control, still faces concrete and symbolic obstacles. what compromise your implementation full in territories made vulnerable. As objectives specific, it is proposed: (1) contextualize the scenario epidemiological of STIs in Brazil with an emphasis on peripheral populations; (2) examine the social determinants and racial what influence the access unequal the testing; (3) identify you limits and advances of policies public facing the prevention, diagnosis and Careful integral of STIs; and (4) discuss the role of multidisciplinary team in the resilience of barriers territorial, social and symbolic to the access to the diagnosis. THE approach considers both your normative aspects of policies as your conditions real of operationalization us services of health. The problem question that guides this investigation is: How can public testing policies of STIs he comes being implemented in communities peripheral Brazilians and to what extent they are able to face the social and structural inequalities that limit the access to the diagnosis early? This question guide one reflection criticism about the relationship between the action of State, to the conditions of life of populations marginalized and the social effects of institutional neglect, with special attention to the dimensions of racism structural, from the stigmatization and from the vulnerability social. To the delimit the focus analytical node crossing between policies public, practices of health and inequalities territorial, this study intends contribute with the debate academic and technical on the realization of the right to health in contexts marked by historical exclusion. It also seeks to support the formulation of more equitable, intersectoral, and territorially sensitive strategies, reinforcing the role of testing as an instrument not just of surveillance epidemiological, but also of justice sanitary and citizenship.

Methodology

This study is configured as qualitative research, of an exploratory and analytical nature, whose objective and to understand critically the effectiveness of policies public of sexually transmitted infections (STIs) testing in peripheral urban communities. The choice of a qualitative approach is justified by the complexity of the phenomenon investigated, which involves multiple social, institutional, and subjective dimensions, impossible of to be captured put quite exclusively quantitative. THE focus focuses on the meanings attributed to testing practices and health policies by different actors involved in the line of care, as well as on the mechanisms that sustain inequalities in access to diagnosis. The analytical section covers official documents (such as epidemiological bulletins, Ministry of Health protocols and municipal health plans), published scientific literature between 2015 and 2025 and studies of case selected in municipalities with history of testing policies in peripheral territories. Document

analysis allows us to compare guidelines institutional with the reality of your application us territories. Furthermore, they were examined experiences successful and criticism reported in periodicals from the area of health collective, service social, nursing and psychology, with the purpose of identify good practices, limits operational and gaps regulations.

Data analysis was guided by the principles of thematic content analysis, as proposed by Bardin (2011), allowing the organization of information into previously defined analytical categories: (1) social determinants and territorial barriers; (2) multidisciplinary action; (3) implementation and sustainability of public policies; and (4) effects of testing on health equity. This technique makes it possible to understand as your elements discursive and practical of policies public policies are articulated with the social context of urban peripheries, revealing tensions, contradictions and potentialities. THE triangulation of sources including regulations institutional, articles scientists and secondary epidemiological data reinforces the validity of the findings, allowing a critical reading about distancing between official discourse and practical reality. This is, therefore, a theoretical-analytical study with the potential to contribute to the reorientation of public policies toward more equitable, intersectoral, and integrated models capable of face to the inequalities structural node access to the diagnosis of STIs in populations made vulnerable.

Results and Discussion

Mass testing for sexually transmitted infections (STIs), although recommended by international organizations as an effective epidemiological control strategy, it presents one distribution geographic deeply unequal node Brazil. The concentration of the resources and structures laboratory in areas central urban prevents peripheral and rural communities from regularly accessing diagnostic services. According to Santos et al. [2], this inequality in supply compromises the ability to SUS response to STIs in historically marginalized populations, making it difficult the interruption of chains of transmission. In addition to the unequal distribution of services, the prioritization of certain population groups in national programs contributes to selective coverage, often alien to the realities local. To the regions North and North East, put example, present gaps persistent in testing of HIV and syphilis, with data incomplete epidemiological data and underreported. This reality reflects a structural pattern of state negligence that perpetuates health inequities, as discussed by Akerman and Franceschini [14], what highlight the need of one planning territorialized and inclusive.

The Family Health Strategy (ESF), with its logic of territorialization and community ties, he has potential significant to enlarge the access to the diagnosis of STIs. Community health agents (CHAs), by working directly in homes and establishing relations of trust with you residents, they are essential in the identification of cases suspects, in the promotion from the testing and node forwarding to your services. According to Oliveira and Giovanella [15], the presence of ACS contributes to breaking down barriers cultural, geographic and symbolic what limit the access to the Careful. However, the positive impacts of these professionals' work are often compromised. put conditions of work precarious, lack of training specific in STIs and care overload. THE absence of standardized protocols for active search testing us territories and the fragmentation between actions from the attention basic and from the surveillance in health reduce the effectiveness from the performance multidisciplinary. Lopes and et al. [16] emphasize that the strengthening from the ESF requires investment permanent in training, professional development and strategies of Careful in network.

THE attention basic the health node Brazil and marked put inequalities racial and territorial that compromise the universalization of the services. Populations black and indigenous people residents in slums and peripheries urban face multiple barriers node access to the diagnosis of STIs, resulting of one institutional racism what structure the system of health. As they point out Werneck and Kalckmann [17], the SUS yet reproduces practices discriminatory to the no incorporate, of form effective, markers social from the difference in your strategies of care. THE mapping of the services shows what to the units of health in the peripheries count with fewer professionals, low ESF coverage, and deficient infrastructure. The distribution unequal of resources impacts directly in the offer of testing fast and in the follow-up clinical of the cases confirmed. These limitations reinforce the logic of exclusion sanitary and make invisible your territories where the prevalence of STIs and higher, making it difficult the surveillance epidemiological and the confrontation from the transmission community [18].

Successful experiences of active search for STIs in urban peripheries have demonstrated what the testing decentralized, ally the listening qualified and the community action, generates better health outcomes. Initiatives such as "Stay Informed Young People," implemented in neighborhoods vulnerable of They are Paul, agreed testing fast, wheels of conversation and actions cultural to engage young people in situation of risk [19]. Such projects show what approaches sensitive to the territory they are more effective than generalist campaigns. Another example relevant are the actions of testing itinerant promoted by non-governmental organizations in partnership with the Unified Health System (SUS), which reach hard-to-reach areas and offer qualified support. These experiences reinforce the importance of protagonism social and from the mediation cultural in the construction of bonds. Rock and Barros [12] highlights that the best results occur when there is integration between knowledge popular and your services formal of health, creating answers contextualized and sustainable. THE program "Alive Better Knowing" is one of the most prominent strategies in the expansion of HIV testing in vulnerable populations, using the peer approach and testing in places no conventional. Although you have obtained results expressive in the

identification of cases in key groups such as the LGBTQIA+ population, their temporal limitation and the dependence of local partnerships hindered their institutionalization [20]. The lack of continuous monitoring and structured financing prevented the

consolidation of this policy in level national. Already the programs "Health at school" and "Office in Road" have the potential to expand access to testing in historically neglected populations, such as adolescents and people in situation of road. Node however, your effectiveness yet and variable between municipalities, depending on intersectoral coordination and professional adherence. One study of Lamb et al. shows that, when good structured, these programs promote diagnosis early and link with care, but they suffer from discontinuity, lack of team qualified and absence of indicators specific to STIs. THE cooperation between the SUS, organizations from the society civil and collectives' peripherals he has proven crucial for expanding access to testing in vulnerable contexts. NGOs with community involvement play a strategic role in mediation cultural, in the mobilization social and in the implementation of actions of prevention with accessible language and a non-stigmatizing approach. According to Dourado et al. (2020), partnerships institutional what value the protagonism social they are more effective in the adherence to testing and node engagement to the Careful continued. However, this articulation still faces bureaucratic and ideological obstacles. The absence of policies public what recognize and finance of form stable you community projects weaken sustainability of actions. In addition of this, the dispute put moral agendas in the field of public health often delegitimize popular knowledge and make the role of peripheral collectives invisible. Mendes and Dias [21] advocate the consolidation of mechanisms formal of cooperation and co-management between State and civil society as path to one response more democratic and effective to the STIs.

5.1. Perspectives Future and Gaps in the Literature

Despite of recognition of policies public of prevention and testing of STIs as an essential part of the Brazilian health response, there is a significant lack of longitudinal studies what evaluate systematically your effects in populations residents in favelas and urban peripheries. Most existing research adopts cross-sectional designs, limiting itself to describing prevalence or specific experiences without monitoring medium- and long-term developments. As Pinto and Barreto point out, (2021), that gap compromises the capacity of the managers of adjust your strategies with base in evidence solid of effectiveness.

The absence of longitudinal data prevents, for example, measuring the impact of testing in mass on indicators as diagnosis early, accession to the treatment and reduction of new infections in territories vulnerable. In addition, from that, makes it difficult to identification of factors contextual what modulate the effectiveness of policies public. To move forward, funding is needed for multicenter and cohort studies that incorporate socioeconomic, racial and territorial variables in order to generate more robust knowledge and applicable the reality of peripheries [22]. Other gap criticism in the literature on STIs refers to the scarce presence from the perspective of users of SUS in the formulation, assessment and revision of policies public. THE predominance of approaches centered on health professionals and institutional logic makes invisible to the experiences, needs and resistances of populations what are directly affected by health actions. As Cardoso et al. [23] point out, listening to users is essential for developing more effective care strategies, culturally adequate and ethically sustained. Academic production that adopts participatory methodologies, such as focus groups, interviews in depth or ethnography in services of health, yet and incipient in the field of STIs. That results in policies lots of times others the reality concrete of the territories, generating low accession or distrust of communities. To overcome this limitation, studies futures must incorporate you users as subjects' assets from the research, valuing their knowledge and experiences as legitimate sources for the production of knowledge in health collective [24].

The complexity of STIs in vulnerable contexts requires interdisciplinary approaches what articulate knowledge from the medicine, nursing, psychology, social service, education and anthropology. However, they are scarce you study what propose replicable theoretical-practical models capable of integrating these areas in an organic and sustainable way. Second Branches and al. (2021), the fragmentation between disciplines and the lack of shared protocols between teams hinders continuity of care and reduces the effectiveness of actions of testing and follow-up. The development of interdisciplinary models that can be adapted to different realities territorial and one urgency node field from the health public. Pilot projects based on community, supported in methodologies collaborative and transverse, demonstrate greater potential replicability. However, its systematization and scientific evaluation are still limited. To advance in this field, it is necessary to produce evidence demonstrating the positive impacts of integrated multidisciplinary practice, including criteria clear of assessment of effectiveness and feasibility [25].

One of the larger obstacles to the confrontation effective of inequalities in health and the absence of disaggregation of the data put markers social as race/color, gender identity and territorial location. Much of the research and information systems still operate with generalist categories that mask inequities and hinder the formulation of targeted policies. As Santos and Lopes [26] state, that invisibility statistic perpetuates the racism structural and the denial of right to health for vulnerable populations. Without indicators that capture the intersections between social determinants of health, such as gender and territory, becomes impossible to understand your mechanisms of exclusion and build answers specific sanitary facilities. THE scientific literature, in that aspect, needs to move forward incorporating methodologies sensitive the complexity from the life in the peripheries and to the impacts of racism institutional. Studies intersectional and analysis spatial criticism represents paths promising to fill in that gap [27].

To the populations trans and non-binary appear between you groups more affected by STIs, especially due to HIV, but they remain invisible in databases and evaluation studies of policies of testing node Brazil. THE absence of variables specific on gender identity in institutional forms and epidemiological research prevents the sizing real of needs and of barriers faced put these subjects. As evidenced put Niffler and Miskolci [28], that omission contributes

to the marginalization sanitary and to the perpetuation of practices transphobic us services health. The literature what treats from the health from the population trans yet and scarce, concentrating in a few centers urban and without extrapolation to realities peripheral. THE lack of disaggregated data compromises the allocation of resources, the planning of actions educational and the training professional adequate. Studies futures must prioritize the production of knowledge centered in the experiences and demands of people trans and non-binary people, incorporating their voices from the methodological design to the analysis of results [29].

Final Considerations

Early diagnosis of sexually transmitted infections (STIs) is an essential step no just to the interruption of chains of transmission, but also to the promotion of one Careful integral and humanized. Under the perspective of the rights humans, access to testing must be guaranteed as part of the right to health, provided for in the Federal Constitution and supported by international regulations, such as the Universal Declaration of the Rights Humans. As highlight Menezes and et al. [30], neglect the diagnosis timely implies in omission of State in the protection from the dignity human and in perpetuation of iniquities historical. The centrality of early diagnosis in the field of public health is related to the capacity of promote interventions fast, prevent complications clinics and reduce the burden of disease associated with STIs. In peripheral communities, this access represents much more of what one response clinic: and one act of social recognition and health inclusion. According to Lima et al. [31], ensuring accessible testing is a mechanism of repair of injustices social and racial accumulated, being fundamental for what the SUS comply your paper of system universal, equitable and integral.

Nonetheless, the recognition legal and normative of that right nor always if translates in public policies effective. THE discontinuity of programs, the absence of strategies culturally appropriate communication and the devaluation of vulnerable populations compromise the operationalization of right to the diagnosis. As Soares and Barcellos [32] point out, the contemporary challenge is not just to recognize that right, but in make it viable put quite of actions concrete, monitored and sustainable. Mass testing alone is not enough to promote health justice; it needs be articulated the policies public consistent, territorialized and sensitive to the specificities of the populations served. When well implemented, associated with campaigns educational, search active and involvement community, the testing becomes a powerful equity tool. As Dourado points out et al. (2020), your effectiveness is directly linked to the presence of trained multidisciplinary teams, infrastructure adequate and planning intersectoral.

THE performance multidisciplinary expands the scope of Careful to the integrate dimensions clinical, psychosocial, and cultural aspects of the testing process. The coordination between doctors, nurses, psychologists, social workers, and community agents favors an approach integral, in what the diagnosis he leaves of to be one end in yes same and raisin the be a point of match to the Careful continued. Almeida and al. [29] argue what and that integration what guarantees bigger accession, minor stigmatization and bigger resolution of actions in health, especially in communities historically neglected. In addition, from that, policies of testing massive what contemplate the diversity of the territories and of the identities of gender, race and class social produce effects structuring node system of health. THE reduction of iniquities raisin for the institutionalization of practices what go beyond of biologicism, hugging one perspective expanded of health. Second Santos and Paula [2], the testing in mass articulated to the Careful multidisciplinary no only reduces the incidence of STIs as strengthens the SUS while tool of justice social.

To the barriers to the diagnosis of STIs no if limit to the field technical-operational: They involve symbolic and structural dimensions that require deeper actions. Strengthening active listening to communities, especially the most vulnerable populations, is an essential condition for building effective care strategies. According to Ferreira and al. [24], to the practices of health must to be built in dialogue with the subjects, recognizing popular knowledge, experiences of exclusion and specific demands of the territories. In that sense, the strengthening from the attention basic assume paper strategic, then and at the level local what if builds the bond between professionals and users. THE ESF, when well structured, with coverage adequate and performance multidisciplinary, and able of guarantee access timely the testing and to the Careful. Node however, to fulfil that function, the primary care it needs be free of practices discriminatory, the what implies to recognize and face the racism institutional, the LGBTphobia and others forms of oppression us services of health (Costa et al., 2021). Put end, the fight the discrimination institutional he must to be explicit in the policies public health. This includes the implementation of protocols of reception inclusive, anti-racist training and anti-transphobic of teams, and systems of ombudsman effective. The omission in front the discrimination structural reproduces to the violence historical suffered put black people, trans, indigenous people and residents of peripheries. As claim Silva and Teixeira [33], public health needs to make an ethical and political commitment to equity, not just as principal abstract, but as practice everyday life [34-37].

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