





CARE FOR THE PERSON WHO LIVES WITH HIV/AIDS IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: to understand the process of caring for the person with HIV/AIDS in the Primary Health Care of a capital in southern Brazil.

Method: qualitative, exploratory and descriptive research, carried out in the Health Centers of this city, from March to August 2015. Sixteen nurses participated through semi-structured interviews, which were organized and codified with the help of the software QSR Nvivo®, version 10. Afterwards, the data were analyzed through comparative analysis.

Results: results were described in two categories: “The inter-subjective encounter given the vulnerability to HIV/AIDS”, and, “Accepting needs and formulating actions given the reality”. Potentialities and weaknesses were evidenced through these categories, such as: reception, long-term care, active search, home visits, and, in return, lacking a formal flow of care for people living with HIV/AIDS, lack of HIV/AIDS line of care and medical/centered care.

Conclusion: the need to implement HIV/AIDS management in primary care was verified, as well as to overcome the fragilities in this care with the aid of implementing a formal care flow, establishing managerial processes and permanent education for the professionals. Then, expanding and qualifying care in HIV/AIDS, with important contributions of the nurse in the perspective of integral care in the process of living with HIV/AIDS.

DESCRIPTORS: Acquired immunodeficiency syndrome. Primary health care. Nursing care. Integrality in health. Humanization of assistance.

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O CUIDADO À PESSOA QUE VIVE COM HIV/AIDS NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: compreender o processo de cuidado à pessoa com HIV/aids na Atenção Primária à Saúde de uma capital do sul do Brasil.

Método: pesquisa qualitativa, exploratória e descritiva, realizada nos Centros de Saúde desta cidade, no período de março a agosto de 2015. Participaram 16 enfermeiros através da realização de entrevistas semiestruturadas, que foram organizadas e codificadas com o auxílio do *software* QSR Nvivo®, versão 10. Após, procedeu-se a análise dos dados por meio da análise comparativa.

Resultados: os resultados foram descritos em duas categorias: “O encontro intersubjetivo frente à vulnerabilidade pelo HIV/aids”, e, “Acolhendo necessidades e formulando ações frente à realidade”. Através destas categorias se evidenciaram as potencialidades e fragilidades, como: acolhimento, longitudinalidade do cuidado, busca ativa, visita domiciliar, vínculo e, em contrapartida, falta de um fluxo formal de atendimento às pessoas que vivem com HIV/aids, inexistência de uma linha de cuidado em HIV/aids e atenção médico/centrada.

Conclusão: verificou-se a necessidade de implantar o manejo do HIV/aids na Atenção Primária, bem como superar as fragilidades nessa atenção com o auxílio da implementação de um fluxo de atendimento formal, firmando processos gerenciais e educação permanente dos profissionais. Logo, ampliando e qualificando a atenção em HIV/aids, com importantes contribuições do enfermeiro na perspectiva da integralidade do cuidado no processo de viver com HIV/aids.

DESCRITORES: Síndrome de imunodeficiência adquirida. Atenção primária à saúde. Assistência de enfermagem. Integralidade em saúde. Humanização da assistência.

EL CUIDADO DE PERSONAS QUE CONVIVEN CON EL HIV/SIDA EN LA ATENCIÓN PRIMARIA DE LA SALUD

RESUMEN

Objetivo: comprender el proceso de cuidado de personas con HIV/SIDA en la Atención Primaria de la Salud de una capital del sur de Brasil.

Método: investigación cualitativa, exploratoria y descriptiva, realizada en los Centros de Salud de esta ciudad, en el período de marzo a agosto de 2015. Participaron 16 enfermeros a través de la realización de entrevistas semiestructuradas, que se organizaron y agruparon con la ayuda del *software* QSR Nvivo®, versión 10. Luego se procedió al análisis de datos por medio del análisis comparativo.

Resultados: los resultados se describieron en dos categorías: “El encuentro intersubjetivo ante la vulnerabilidad por el HIV/SIDA”, y “Recolectando las necesidades y formulando acciones ante la realidad”. A través de estas categorías se pudieron evidenciar las potencialidades y debilidades, como: acogida, longitudinalidad del cuidado, búsqueda activa, visita domiciliaria, vínculo y, en contrapartida, falta de un movimiento formal de atención a las personas que conviven con el HIV/SIDA, inexistencia de una línea de cuidado del HIV/SIDA y atención médica enfocada.

Conclusión: se pudo comprobar la necesidad de implementar una gestión en relación al HIV/SIDA en la Atención Primaria, así como superar las debilidades en esta atención con la ayuda de la implementación de un flujo de atención formal, reafirmando los procesos gerenciales y de educación continua de los profesionales. Luego, ampliar y calificar la atención en HIV/SIDA con importantes contribuciones del enfermero en la perspectiva de la integralidad del cuidado en el proceso del convivir con el HIV/SIDA.

DESCRITORES: Síndrome de inmunodeficiencia adquirida. Atención primaria de la salud. Integralidad en salud. Humanización de la atención. Atención de enfermería.

INTRODUCTION

Since the appearance of the Human Immunodeficiency Virus (HIV) in the 1980s, thousands of people are still infected every year by this agent. In Brazil, since the beginning of the epidemic, 798,366 cases of AIDS have been registered, which is the basic cause for 290,929 deaths.¹

In recent years, the country has been reporting stable prevalence and incidence rates. Thus, the disease assumed characteristics of a chronic condition, with a therapeutic control facilitated and more accessible to People Living with HIV/AIDS (PLWHA).² As such, HIV/AIDS care requires a different perspective on the issue, leading to holistic approach, service coordination and focus on Primary Health Care (PHC).³

In this sense, the Ministry of Health of Brazil turns to the importance and discusses this new conjuncture. In addition, it has launched a manual for the implementation of HIV infection management in PHC and has promoted the dissemination of successful disease management practices at the primary level, pointing to a change in the care model that, until then, is centered in Specialized Care Services (SCS).⁴⁻⁵

Studies conducted on HIV/AIDS under PHC are still incipient. In any case, they already show that this reorganization of the care model promotes the expansion of early diagnosis, improved accessibility to treatment, the conduction of PLWHA retention strategies in the services through longitudinality and territoriality, and the integrality in care in HIV/AIDS.^{3,6-7}

Although there are significant potentialities that point towards the reorganization of HIV/AIDS care model, there are significant difficulties in implementing this proposal, such as: the level of training of professionals in the of HIV/AIDS field; the risk of breach of confidentiality; and, the managerial problems of PHC, namely: excess of demand, human resources deficit and difficulties of articulation in the Care Network.²

In order to elucidate how PLWHA care occurs in the reality of PHC, in its potentialities and fragilities, as well as to problematize ways to a positive change, it was sought to investigate the issue from the perspective of nurses working in PHC network. A capital of southern Brazil, considered the Brazilian capital with the best performance in the National Program for Improving Access and Quality of Basic Care (PMAQ).⁸

Therefore, this research aimed to understand the process of care for people living with HIV/AIDS, in the Primary Health Care in a capital of southern Brazil.

METHOD

This is a qualitative, exploratory and descriptive research carried out in the Health Centers in a capital of southern Brazil. This city is composed of an estimated population of 477,798 inhabitants, with a Human Development Index (HDI) of 0.847 and a socio-demographic situation similar to developed countries, where the aging of the population is accelerated and there is a low rate of fertility.⁹⁻¹⁰

The municipality has a PHC network being currently organized in four health districts: North, South, Continent and Center. In addition, PHC network has 49 Health Centers that work in the Family Health Strategy (FHS) modality, two Emergency Care Units, four polyclinics, a Psychosocial Care Center, two Psychosocial Care Centers for Alcohol and Drugs (CAPSad) and a Psychosocial Care Center for Children and Adolescents (CAPSi).¹¹ (Centro de Atenção Psicossocial infanto-juvenil – CAPSi)

With regard to HIV/AIDS care, the municipality has two Testing and Counseling Centers (TCC), two Polyclinics with specialized care for PLWHA and its respective Drug Dispensing Units (DDU). In addition, all health centers in the municipality should carry out early diagnosis, counseling and management of HIV/AIDS infection, in a manner shared with specialized services.^{10,12} There were nurses working in the five Health Centers, which were chosen for this research because they were the largest (in number of FHS teams) of each district, five of which the municipality was divided at the time.

The participants were selected taking into consideration the inclusion criteria proposed for the study: having six months of experience at the date of data collection in the role of nurse practitioner, and/or coordinator of the Health Center or nursing resident in Family Health; and, the exclusion: nurses who are not performing their activities regularly at the Health Center for a period of more than two months at the date of data collection, due to departures of any nature. Therefore, the eligible population for this study was 25 nurses. It is recorded that the project complies with the ethical precepts provided by Resolution n. 466/2012 of the National Health Council.

Data were collected from March to August 2015 through semi-structured interviews that addressed thematic issues, such as: care for PLWHA in PHC; matrix support between SCS and PHC; the process of referencing and counter-referencing; and, the integrality in the care for PLWHA in PHC. A previously evaluated instrument was used with a professional that complied with the criteria of this research.

The data collection meetings were held in the professionals' workplace, had an average duration of 30 minutes and were recorded in audio and later transcribed in full in the text editing program Microsoft Word® version 2010.

The number of participants was established based on the criterion of empirical saturation. In order to clarify the moment of evidence for the saturation of the interviews one used the data treatment strategy that allows to check the saturation of the sources. This proposal is developed through eight steps. During this research, the step corresponding to the compilation of the individual analyzes was omitted since it does not apply to this study.¹³

In this strategy, the authors advise that saturation should be considered only after the accomplishment of three interviews with no evidence for new statements.¹³ Thus, after applying the method, it was evidenced that the data saturation occurred in the 16th interview, and already with the development 63 different statements, as it happens in Table 1.

Table 1 – Distribution of the frequency of statements in the interviews. Florianópolis, SC, Brazil, 2015.

Interview order	New statements	Reproduced statements
1st interview	29	0
2nd interview	5	24
3rd interview	7	31
4th interview	1	27
5th interview	11	29
6th interview	3	31
7th interview	2	27
8th interview	0	25
9th interview	0	38
10th interview	2	27
11th interview	2	30
12th interview	0	38
13th interview	1	32
14th interview	0	26
15th interview	0	23
16th interview	0	16
Total new and reproduced statements	63	424

For organizing and codifying the analyzed data the following *software* for analysis of qualitative and mixed data QSR Nvivo®, version 10 was used. Just for analyzing the collected data one applied the comparative analysis. This method suggests the conduction of comparisons not only of incidents in order to classify them, but theoretical comparisons that aim to stimulate reflection on the properties and dimensions of meanings.¹⁴

The participants and their speeches were identified at the end of each corresponding section with the letter “E” (interviewed), followed by the interview order number, thus preserving the participants’ confidentiality.

As limitations, it is being pointed out that it is impossible to carry out a field study for all the population eligible for the study, due to the limited timeframe for performing the study. In addition, one also cites the non-approach to the PLWHA perspective, since that, in the absence of a structured care network and the secrecy on this population, it became impracticable to implement this aspect.

RESULTS

Of the 16 participants in this research, two worked as nurse-coordinators of the Health Center, one as a nursing resident and the other as nurse assistants of the FHS. Table 2 provides others information about the characterization of the respondents, such as age, gender, time in the position and the higher degree of complementary education.

The analysis of the conducted interviews originated two main categories with their respective thematic units, which will be submitted below: “The inter-subjective encounter given the vulnerability to HIV/AIDS”, and, “Accepting needs and formulating actions given the reality”.

The inter-subjective meeting given the vulnerability to HIV/AIDS

The arrival of PLWHA in PHC occurs in two ways, either by seeking diagnosis and specific care to HIV/AIDS infection, or when the diagnosis is already known by the individuals and their search for the Health Center is not directly related to the condition of infection, but to other health needs: *people, they come to the unit in two ways, like this: for diagnosis or with a diagnosis (E03).*

Table 2 – Characterization of the research participants. Florianopolis, SC, Brazil, 2015.

Identification	Gender	Age	Performance in the position	Specialization	Master’s degree
E1	F	24 years	1 year	No	No
E2	F	54 years	14 years	Yes	No
E3	F	31 years	2 years	Yes	Yes
E4	F	31 years	1 year	Yes	Yes
E5	F	41 years	10 years	Yes	No
E6	F	31 years	1 year	Yes	No
E7	F	35 years	7 years	Yes	No
E8	M	43 years	5 years	Yes	No
E9	F	43 years	6 years	Yes	No
E10	F	24 years	6 months	Yes	No
E11	M	27 years	3 years	Yes	No
E12	F	52 years	10 years	Yes	Yes
E13	F	33 years	1 year	Yes	No
E14	F	44 years	13 years	Yes	No
E15	F	32 years	3 years	No	No
E16	F	32 years	7 months	No	No

The characteristic of HIV/AIDS care in PHC stands out in the professionals' discourse, which is developed through spontaneous demand, and not through programmatic actions that could guarantee the offering of health actions and services aimed at the adequate management of issues surrounding the living with HIV/AIDS.

PHC can be a potentiating agent for early diagnosis, since its competence equally, is carrying out rapid testing for HIV detection, with a view to increasing access to diagnosis. Therefore, early diagnosis also provides treatment at the onset of the disease, essential for controlling the infection and promoting quality of life. Thus, an expanded project is needed to support the qualification of PLWHA care in PHC.

In HIV/AIDS care, the arrival of the individual for the diagnosis still generates enough anxiety in the professionals: *It's not always easy to give bad news... Being the messenger of bad news is cruel, sometimes. So, I have to be well.* (E05).

During the interviews it was possible to show that the nurses perceive the moment of the diagnosis as an opportunity of great anxiety for both subjects (professional and PLWHA), which allows to infer that this perspective is directly related to the stigma that the disease is still causing and the need to prepare the professional for acting then.

The diagnosis of HIV seropositivity is seen as a "death sentence", a moment of user fragility given the impact of the diagnosis. *There is still a lot of stigma and prejudice: "I have HIV, am I going to die?". It is a death sentence. And this causes a lot of fear in people* (E01).

Therefore, the report of fear and the desire to maintain secrecy regarding the diagnosis are common. And this secrecy often leads the users to not seek care at the Health Center being closest to their home: *so, there are many patients who do not prefer to come to the health unit, who prefer to go on the specialized clinic, which is further away from home* (E06).

It is of the utmost importance for the professional to adopt a receptive attitude towards the individual, demonstrating empathy for the subject and establishing a bond: *I know I'm going to give bad news that will really change that person's life.* (E05). *Then, they need to feel themselves welcomed when arriving at the unit. [...] He needs to have the bond with the team* (E06).

As a starting point for implementing effective management of HIV/AIDS issues in PHC, it is important to establish a link of trust among professionals and users, which is intensified, especially at the time of diagnosis.

It is proven, given such condition, that the meeting between professional and PLWHA is difficult for both, either for the impact of the illness or the proper professional personal capacity/to establish a therapeutic communication in this situation. Therefore, promoting a close and trusting relationship is essential for overcoming the frailties in the caring process.

Accepting needs and formulating actions given the reality

The most present discourse in the interviewees' speeches was the lack of a formal flow for following up PLWHA in PHC. *There is no such thing, as a formal flow* (E12). *Each case is different. There is no specific care. It is person-centered* (E07).

In spite of lacking a formal flow for the follow-up, the professionals' performance demonstrates a profile of engagement and proximity to the PLWHA, through PHC's work technologies. *I follow this up more closely, I chase after... I mark return in the unit, I make a home visit, I call the person, I ask for the help of other members, such as the technicians, anyway...* (E02).

In order to instrumentalize the person assisted in their self-care, the professionals use the technologies of care that are found in the PHC, such as: longitudinality, bond, individual appointment, home visit (as a strategy to know the reality of the other and the approximation between health service and user), active search and multi-professional attention.

PHC's professionals overcome the difficulties of not having a formal flow in HIV/AIDS care still established, through mobilization in favor of and for implementing a committed and resolute care, using the tools that their work process provides.

Regarding the characteristics of this care, the nurses highlighted the actions for awareness, orientation about the disease and its coping, as well as monitoring the therapeutic adherence. *We do this work more in the sense of causing awareness, guiding on preventing the contamination, on life in society, on how to face this (E02). So, what we do more is seeing if the patient has joined the treatment (E15).*

Nurse discourse reveals an intertwining of the words "awareness" e "person-centered approach", using both expressions to characterize a care that goes far beyond health education actions. That is, a singular attention oriented to biomedical, psychosocial and cultural issues, as well as a committed attention with those who seek it, with a bond and co-responsibility for care.

In spite of the potentialities present in the PHC work process, previously exposed, nurses report that HIV/AIDS care is still characterized by medical-centered care, with little recognition for the nurse role: *it passes more by the medical care (E09). There is the Ministry's protocol on sexually transmitted disease, but thus, I do not see much of the participation of the nurse, nor in the reality that we live here (E11).*

Although the nurse is the catalytic agent of multi-professional care in the Health Centers, as well as, they have guaranteed their space in conducting HIV's diagnosis, counseling, follow-up, promotion and monitoring of ART, the interviewees report that it is about a low visibility performance, or more, of ignorance of the real role of nurses in relation to HIV/AIDS related issues.

In summary, those data point out that, although there are protocols and ministerial directives for HIV/AIDS care in PHC, there is no flow and systematization of care, leading the professional to respond to the needs/complaints/problem and develop care with the available resources in order to ensure quality care.

DISCUSSION

PLWHA access to Health Centers characterizes a flow of care directed to the spontaneous demand, not to programmatic actions that seek to offer and guarantee services and actions in health, which provide adequate management to the individual needs of each PLWHA.

In addition, this characteristic (spontaneous demand) contributes little to community awareness activities in HIV/AIDS prevention, early diagnosis, bonding establishment and empathy among health center professionals and PLWHA, continuity of care and promotion of ART adherence.

The lack of programmatic actions for HIV/AIDS care in PHC is directly related to the fact that, in Brazil, PLWHA care still remains largely centralized in SCS, therefore, clinical actions and the ties and empathy of PLWHA are associated to the secondary service teams, not to the PHC team. In addition, the logic of action in this is still very focused on ministerial programs, such as: Hiperdia (hypertension day program), Child Care and Women's Health Care. Allied to this, the PHC did not officially assume a flow of care for the demands of HIV infection, thus contributing, for the non-recognition of this issue with a receptor for the demands related to the infection.

However, it is essential that PHC should be seen as a service that is responsible for HIV/AIDS care, since that, as the main gateway to the health system, it is the place where the user's first contact with the system takes place, with aspects of geographical accessibility, often superior to what SCS can offer. Therefore, it is essential for PHC to improve their organizational accessibility mechanisms, enabling the capacity to produce services and to respond to the life and health demands of PLWHA. In addition, it should not restrict its action to the physical room of Health Centers, but be able to identify and intervene in obstacles that hamper or facilitate the population's access to these environments.¹⁵

However, the perspective for coordinating the care and articulation of services should be considered in order to improve the accessibility of the individual to the different rooms of health production, so that all of them are aimed at achieving a common objective, which is to respond to the health needs of the person in an integrated way, through an efficient service network.¹⁵ And this topic gains special attention in HIV/AIDS care, since there is still a transition model where, in most Brazilian cities, HIV/AIDS care is concentrated in the SCS, a component of the average health complexity. In addition to the fact that, because it is a chronic disease with complex and continuous therapy, this user will invariably need, at some point in life, to access different professionals and their respective specialties, as well as different sites for providing health care services.

Since the onset of the AIDS epidemic, there has been a strong association of the disease with these at-risk groups (injecting drug users, homosexuals and sex workers) and deviant behaviors such as promiscuity.¹⁶ In addition, the fear of contagion, associated with the lack of knowledge of the transmission mechanisms of the virus, provoked and still provokes strong discrimination, which defies the daily life of PLWHA.¹⁷

Therefore, the moment of diagnosis is seen as an experience of great uncertainty and insecurity for the future, even of great trauma.¹⁸⁻¹⁹ Although HIV/AIDS infection, when well managed, shows excellent prospects for quality of life and many years of survival, unlike what happened at the beginning of the epidemic, an irreversible and stigmatizing diagnosis remains.²⁰ The professionals feel vulnerable to this situation and express the need for emotional preparation to lead the moment on the disclosure of seropositivity, or the revelation of the bad news. That is, the professionals feel unfit and/or unprepared for conducting this moment because they identify their emotional and technical vulnerability given such situation.

The disclosure of the HIV positive diagnosis is considered a bad news communication, since it is characterized by an action generating *stress* and anxiety for the involved subjects, be they patients, relatives and professionals. Its disclosure, however, although it is a complex and difficult task, reduces uncertainty and is a fundamental aid to the acceptance of diagnosis and adherence to treatment.²¹ A professional prepared for the moment of bad news is able to express a receptive attitude. This reception, is essential for the construction of an integral care and for the concretization of humanizing relations among the subjects involved in the process.²² Likewise, it is necessary that training institutions foster the communication skills in health through educational tools.

Another attribute of the PHC that stands out from the reflection of the professional discourse is the longitudinality of care. This tool comprises a regular source for providing health services, accompanying the individuals in their life process, where the professional and the user are able to maintain an empathic relationship and whose bond remains, with a view to the precise recognition of the aspects of life that interfere in the individual's health condition.¹⁵ Thus, it is necessary for the PHC health team to share care with PLWHA with SCS as a reference for attention to the more complex issues surrounding HIV infection and its therapeutics.

As part of the longitudinality, welcoming is cited as an essential tool to establish the bond among professional, health service and user, thus facilitating the establishment of a continuity relationship among the agents. It is worth noting that this does not mean a single moment or an isolated strategy, that is, the action of receiving the users upon their arrival at the Health Center.¹⁵ Reception is an attitude that occurs in every contact between professional and user, and as such promotes the establishment of a trust relationship between their characters, where PLWHA seem to deal better with the psychic suffering of the diagnosis, express their feelings and anguishes, overcome difficulties in revealing the diagnosis, and are open to health information actions.²³ Therefore, it is inferred that the reception of the individual can be reflected in the acceptance of the new condition, in adherence to treatment and in the prevention of HIV transmission.

The integral care of people with HIV/AIDS in the PHC should promote, above all, the establishment of a bond between professional and user, as well as, co-responsibility through listening and analysis (non-technological care).

The relationship of empathy and trust established between professional and user has proven to be an important tool in addressing issues related to confidentiality, privacy and confidentiality for HIV/AIDS diagnosis. Being the welcoming a unique moment for the definition of the handling of the private information, in agreement between the assisted subject and the health professional.²⁴

Secrecy becomes a topic of extreme importance in the field of HIV/AIDS, especially when it comes from the perspective of PHC care, because it directly interferes with the longitudinal care conducted by FHS professionals and reduces users' search for other health services that are their residence, due to the fear related to breach of secrecy.²⁴

In this sense, a study conducted with PHC health professionals showed that both confidentiality and confidentiality gain new contours when it comes to a multi-professional team, mainly because it includes Community Health Agents (CHA), which besides acting in the services health centers are also residents of the place where the cared PLWHA live.²⁵ Even though more than 15 years have passed since this study, questions regarding confidentiality of the diagnosis are still taboo to be worked on by professionals and users so that PHC is recognized as a welcoming, effective and efficient space to address related issues living with HIV/AIDS.

Therefore, it is indispensable that the professionals approach the work dynamics in the PHC together with the PLWHA cared by that team and explain the relevance for the revelation of the diagnosis to the other professionals that accompany them, but always with respect to the autonomy of the user's decision and signing pacts of confidentiality.

Another important factor in nurses' speeches was the importance of the person-centered approach and their needs, where they demonstrate a denial of the summary of the meeting between subjects (professional and PLWHA) to a care technology (consultation) with clear objectives and pre-determined actions, which characterizes one of the meanings of integrality.²⁶

The integrality of care provides, among its propositions, a redefinition on the way of care, in which priority is given to the establishment of the bond, acceptance and autonomy of the subjects, valuing their singularities and subjectivities, and, above all, constructing care possibilities centered on the users and their needs. Exercising integrality involves the need to rethink practices and conformations of the public health services, still characterized today by the discontinuity of care.¹⁵

Another important point in nurse speech is the word "awareness". Awareness is understood as a communication strategy that involves health information and guidance related to the complexity and specificity of each case, that is, it involves the inter-subjective encounter and the interpersonal relationship between two subjects. Thus, knowledge of the specific field of HIV/AIDS and the contents worked in a health care are only a guide for action, flexible to each context of life in which they are applied.²⁷ Awareness, then, is an aid/benefit/utility tool for PLWHA, or it is the way to provide tools so that the others (the users) may help themselves.

Another point for discussion concerns the nurse's role regarding HIV/AIDS care, from PHC perspective. The social representation on the role of nursing in health actions is codified through operational technical work (through the execution of procedures and techniques), humanistic work, and managerial work.²⁸ Being that the latter often prevails over other actions in the nursing work process.

Still, considering these three meanings given to nursing work, the subjective perspective of the nurse's role in HIV infection issues is highlighted, since it is embedded in the user's reception, in the qualified listening, in empathy and in the bond. This is because, even if it is a pathology that has viable biomedical therapy, there is still no cure, as well as, it demands great mobilization of affective

and emotional aspects, since its diagnosis has a significant repercussion in issues of stigma and prejudice.²⁸

Living under a medical and highly technological cultural paradigm makes nurses themselves perceive the technological care (or operational technical work) as their object of work and no longer the complexity of the human living process (humanistic work).²⁹ In addition, nursing has low professional visibility, little recognition of its scientific condition and autonomy, and its image is highly tied to its historical trajectory.³⁰ Consequently, nurses themselves tend to reproduce a view of the collective sense that their work is considered invisible, as evidenced in the speeches.

In view of such, it is assumed that it is of great importance to promote the understanding of nursing work as an activity of simultaneous assimilation. That is, the nurse role in the field of HIV/AIDS is carried out through the understanding that it deals with pain, suffering, life and death of the human being, and that, therefore, care technologies exist due to this one, the human being, and should not suppress nor surpass the subjective perspective of the nurse performance.²⁸⁻²⁹ Therefore, the nurse is rather a transforming and indispensable agent for the care, who uses scientificity in his daily practice and who must develop their professional authority autonomously.

Another factor to be analyzed is that the ignorance on the role of the nurse, cited by the interviewees, may still be related to the technical knowledge they hold about HIV/AIDS and the therapeutics involved in the process. Therefore, actions that seek to promote the qualification of these professionals to act in HIV/AIDS care and in the reflection about the properties that construct this care may contribute to the visibility of the nursing role and even to the professional motivation of the nurses.

CONCLUSION

In view of the objective proposed in the study, to understand the process of HIV/AIDS care in PHC, this study revealed that nurses working in Health Centers feel unprepared for approaching PLWHA and their life and health issues, related to the time of diagnosis. That is, they perceive a care developed in the medical/centered perspective, associated with the fact that they characterize their actions as low visibility. Therefore, this fact points to the importance of the reflection on the training of nurses and strategies for continuing education that seek to prepare this professional in an adequate way so that they may enjoy all the possibilities of care in HIV/AIDS, and consequently, enabling safer and better quality care.

Another item to highlight is implementing HIV/AIDS care flows in PHC. PHC has not yet officially assumed a flow of care and management of HIV infection issues, so that care still remains focused on medium complexity services, which contributes to the non-recognition of Health Centers as a receptive environment for the needs of PLWHA care. This evidence is in line with the current trend of the Brazilian Ministry of Health, which seeks to implement Lines of Care in the most diverse fields of health care.

In addition, it should be pointed out that the fragilities highlighted throughout the text show that it is not a problem being exclusive to HIV/AIDS care in PHC perspective, but rather in relation to other program-related areas, such as Hipertensão, Women and Children Health Care, among other programs. Therefore, it is understood that since the expansion and reformulation of the PHC we still face obstacles that hamper the implementation of the National Policy of Primary Care in its totality, generating a direct impact on the quality of the provided services, the work process and motivation of the PHC professionals, and consequently, on the health status of the cared population.

It is suggested that new researches may be conducted, problematizing the issue of the implementation of AIDS management focused on PHC, since that this perspective is still represented under an incipient way in the literature, in addition, seeking the perspective of the PLWHA on the management of infection by HIV/AIDS in PHC and the reflection and publicity of successful practices in HIV/AIDS care at this care level.

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NOTES

ORIGIN OF THE ARTICLE

Article extracted from the thesis - Comprehensiveness in care for the person with HIV/AIDS in Primary Health Care: the perception of nurses, submitted to the Nursing Undergraduate Program. *Universidade Federal de Santa Catarina*, in 2016.

CONTRIBUTION OF AUTHORITY

Conception of this study: Colaço AD, Meirelles BHS.

Data collection: Colaço AD.

Analysis and interpretation of data: Colaço AD, Meirelles BHS, Heidemann ITSB, Villarinho MV.

Writing and/or critical review of content: Colaço AD, Meirelles BHS, Heidemann ITSB, Villarinho MV.

Review and final approval of the final version: Colaço AD, Meirelles BHS, Heidemann ITSB, Villarinho MV.

ETHICS COMMITTEE IN RESEARCH

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CONFLICT OF INTEREST

There is no conflict of interest.

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ERRATUM: CARE FOR THE PERSON WHO LIVES WITH HIV/AIDS IN PRIMARY HEALTH CARE

Regarding the article “CARE FOR THE PERSON WHO LIVES WITH HIV/AIDS IN PRIMARY HEALTH CARE”, with DOI number: <http://dx.doi.org/10.1590/1980-265x-tce-2017-0339>, published in *Texto & Contexto - Enfermagem*, volume 28, elocation e20170339:

Where was written:

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Where was written:

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Now read:

Secretaria Estadual da Administração de Santa Catarina. Florianópolis, Santa Catarina, Brasil.