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ORIGINAL ARTICLE

TRANSFER OF HIV CARE TO PRIMARY CARE: NURSES' PERSPECTIVE[1]

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ABSTRACT

Objective: to understand the experience of being a nurse in the Basic Health Unit in caring for people living with HIV, considering the senses built into the daily practice of care. **Method:** a descriptive study, with phenomenological approach, conducted with nurses from a municipality in southern Brazil, between September and November 2023. The analysis of the discourses was based on the Qualitative Analysis of the Situated Phenomenon: understanding of meanings and approximation, identifying the units of meaning, which were grouped in categories. **Results:** The speeches of the 13 nurses revealed four thematic categories. The first shows the tension experienced in caring for people with HIV. The second points to the rupture of the bond between BHU and user, marked by secrecy, stigma and protective distance. The third highlights overload and lack of support as limitations. The fourth expresses the desire for training and institutional support, highlighting the mismatch between guidelines and professional reality. **Final thoughts:** Being a nurse in the care of people living with HIV at BHU involves ethical tensions, insecurity and lack of support, but also desire for bonding and reorganization of care. The findings point to the need for policies that are more sensitive and integrated with the reality of services.

Keywords: HIV. HIV testing. Health Policy. Primary Health Care. Public Health Nursing.

INTRODUCTION

Human Immunodeficiency Virus (HIV) infection remains, even after decades of confrontation, a phenomenon of profound sanitary, social and subjective complexity. In 2023, it was estimated that about 39 million people lived with the virus, and approximately 14% were unaware of their serological condition(1). This data, by itself, reveal how much the diagnosis still escapes the territories of daily attention, reinforcing inequalities and making it difficult to control transmission (1). In Brazil, the numbers also remain significant, with more than 43,000 new cases reported that year, keeping HIV/AIDS as a priority issue in health policies(2).

In countries with marked regional disparities, such as Brazil, access to diagnosis and care is uneven(3). In the face of this, the decentralization of actions to cope with HIV to the scope of primary care is proposed as a strategy to expand access and qualify care(3,4). In the field of management, this decentralization was operationalized through the introduction of rapid tests in Basic Health Units (BHU), especially aimed at prenatal testing and the attention of users seeking to identify the serological status (5). Professionals such as nurses, doctors, pharmacists and dental surgeons were empowered to perform, interpret and record rapid tests for HIV, expanding the technical capacity of the BHU in coping with the epidemic(4,5).

However, decentralizing does not only mean redistributing tasks, but also rethinking the place of care, its meanings and ethical implications. This requires not only protocols and flows, but listening to subjects who experience daily clinical appointments, moral dilemmas and institutional limits(6).

The nurse, central figure of the BHU team, is among the professionals qualified to perform and interpret the rapid tests(7). The role of nursing, in this context, goes beyond the technique: it involves

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listening, bonding and recognizing the complexity that crosses the experience with HIV(7).

Nevertheless, decentralization is not a neutral process. The incorporation of new responsibilities into the daily life of BHU requires more than technical skills: it demands institutional reorganizations, continuous support and ethical reflections on the place and manner in which care is provided(6,8). In the center of this scene, the nurse presents himself as a subject who, besides operating protocols, experiences care in its sensitive and relational dimension. It is in this daily life that he interprets the world, welcomes the other and acts – or withdraws – before the multiple demands that involve caring for people living with HIV(7).

Despite the expansion of nursing responsibilities in the care of people living with HIV, there are still few investigations that seek to understand how this care is lived, felt and interpreted by professionals themselves, especially in the environment of BHU. In general, studies focused on the evaluation of indicators, structure of services or adherence to treatment prevail, leaving in the background the modes of being and acting of the subject who cares.

Therefore, recognizing that care is not limited to the application of guidelines, but involves a set of experiences, emotions, decisions and silences that cross the professional daily life, this study aimed: to understand the experience of being a nurse in the Basic Health Unit in caring for people living with HIV, considering the meanings built into the daily practice of care.

METHODS

This is a descriptive study, with a qualitative approach, in the light of the phenomenological reference. Phenomenology, as an epistemological foundation, seeks to understand the lived experience as perceived by the subjects, suspending previous interpretations and naturalized categories. This movement proposes to capture the senses attributed by participants to the phenomenon, as it manifests itself to consciousness, before any conceptual or normative explanation(9).

The survey was conducted in a municipality in the Brazilian southern region, with approximately 409,000 inhabitants, Human Development Index (HDI) of 0.8 and 90% urbanization(10). The city has 36 Basic Health Units (BHU), distributed in five administrative regions, with different levels of structure and care coverage.

The participants were nurses working in the city’s BHU participated, regardless of care compliance: member of the family health team (FHT) or not. The inclusion criteria were: graduation in nursing, professional link with a BHU for at least six months, and previous experience in caring for people diagnosed or suspected of HIV, resident in the area covered by the BHU in which he works. We adopted the minimum criterion of six months at BHU in the city to favor the inclusion of professionals with sufficient experience to reflect on the phenomenon studied, allowing a deeper understanding of situations related to care for people living with HIV. Professionals absent for vacation, leave and absence at the time of collection were not included. The sampling technique was systematic for convenience, listing participants for the study until the internal logic of the study object was understood(11).

Data collection took place between September and November 2023. The interviews were conducted jointly by two female researchers — a graduate student and a doctoral candidate in nursing — both of whom were female, previously trained in qualitative research and who had no relationship with potential participants. Moreover, the doctoral student had experience in acting in PHC services. The participants were invited in person at the workplace, after presentation of the research objectives.

The interviews were individual, conducted in a private environment and guided by the guiding question: "Tell me how was/is it for you to attend a person diagnosed or suspected of HIV at the BHU where you work?". All interviews were recorded with digital equipment and had an average duration of 26 minutes. The script was adjusted punctually throughout the collection, based on contributions emerging from initial interviews, respecting the methodological flexibility of the qualitative approach(11).

The interviews were fully transcribed and texted immediately after their completion. Each participant was interviewed only once. The participants did not return the transcriptions for validation, because the analysis focused on the meanings expressed spontaneously in the speeches, without pretension of subsequent reconstruction.

The analysis and construction of the themes occurred in an inductive way, based on the Qualitative Analysis of the Situated Phenomenon, subdivided into four main phases: a first complete reading reaching the understanding of meanings and generating approximation with the scenario of the subjects; the second stage was an in-depth reading of the speeches, seeking to identify the units of meaning – based on the main researcher's perspective – about the phenomenon in question; in the third stage, the units of meaning that revealed the phenomenon more deeply were separated; at the end, in the fourth stage, the units were categorized and named by the authors, so as to understand the meanings attributed to the phenomenon(12,13). The phenomenological analysis guided the interpretation, allowing the immersion in the lived and the articulation of the categories with the modes of being, feeling and acting of the subjects in the investigated context.

In order to protect the identity of the deponents, excerpts taken from the nurses' testimonies were identified with the letter 'N', followed by a numeral referring to the order in which the interview was conducted.

The study was approved by the signatory institution's Standing Human Research Ethics Committee (CAAE: 73951423.4.0000.0104), and its development followed the ethical principles recommended by the Consolidated Criteria for Reporting Qualitative Research (COREQ)(12). All participants were informed about the research objectives, confidentiality of information and voluntary participation. The Informed Consent Forms (ICF) were signed before the interviews.

RESULTS

The participants were 13 nurses, being 11 female, 12 considered to be of white ethnicity/color, and all had at least one *Latosensu* graduation and 1 with *Stritosensu*graduatioin. The time spent in PHC ranged from one to 30 years, 9 of which were more than 10 years old. The nurses interviewed worked in 10 different BHU, three in the southern region of the city and seven in the northern region. There were also three refusals.

Four thematic categories emerged from the analysis. Next, the identified categories are presented, accompanied by units of sense representative of the narratives, in order to highlight the meanings attributed by the participants and preserve the authenticity of the experiences lived.

Living care in tension: between technical knowledge and fear of stigma

In this category, the care for people seeking HIV diagnosis or living with the virus is experienced by nurses as a space of widespread tension and insecurity, highlighting the difficulty in enunciating an HIV diagnosis, as a "disease that no one wants to have".

> "It's very difficult to treat someone who is HIV-positive. Because HIV is a disease that everyone thinks they'll never get. When they take the rapid test, they do it thinking it won't be HIV-positive."(N1)

The speech about the virus is lived as a delicate ethical border, which demands much more than mastery of protocols: it requires emotional preparation, sensitivity and acceptance before a reality that still refers to exclusion and suffering. The close relationship with the user, characteristic of BHU, intensifies the emotional load, especially in sensitive cases such as pregnant women or people who did not expect the result.

> "Today I don't feel safe treating an HIV-positive person, because they need knowledge, to know about transmission, they are human beings, they need our attention."(N4)

The professionals reveal full anguish in having to deal with an HIV diagnosis, even if there is a treatment. The bond formed by the close relationship between the PHC nurse and the population treated generates an emotional involvement that makes the weight of the diagnosis even greater.

> "In my career, the moment I was most distressed was when I was breaking the news of an HIV-positive test to someone who didn't know and hadn't even sought testing. It was a pregnant woman, so it was distressing because she never imagined the pregnancy, and that's what she told me. When I took the rapid test at the start of prenatal care, I did it and it came back HIV-positive. It was distressing because it involved not only her, but the baby as well. That was what shook me the most. This case shook me even more because of the emotional

> involvement.” (N8)

All the emotional weight felt by health professionals is linked to the beliefs of a fatal disease, in addition to the fear of stigma and social rejection, which mobilize a continuous emotional preparation based on professional ethics.

When the bond breaks: secrecy, stigma, and distancing in care

Confidentiality is a fundamental aspect and a right of the person, for their protection. However, nurses experience the confidentiality of HIV-related diagnosis and care as a barrier to continuity of care. While PHC care is characterized by continuity and longitudinality, when it comes to HIV, the person rarely returns to the BHU after diagnosis, centralizing their needs in a single service and losing the bond that was formed with the patient until there. The lack of integration between BHU and specialized services disrupts the process of shared care, creating zones of silence among institutions. Nurses report lack of knowledge about the follow-up of users diagnosed with HIV, being informed only if the own patient reveals spontaneously. The fragmented information system and the requirement of offices and bureaucracies to access medical records generate frustration and a feeling of professional impotence.

> “BHU does not have access to the medical records of anyone with HIV; they are confidential, they have no access whatsoever. After the test, if the test is HIV-positive, the laboratory notifies BHU to perform a second collection. If the second collection is HIV-positive, the patient is referred to the specialized outpatient clinic, and BHU has no further information.”(N5)

> “Unless the patient comes in and tells us they're HIV-positive, we have no way of knowing anything. We treat them like any other patient.”(N11)

The isolation of the specialized HIV outpatient clinic makes communication between services difficult and even impossible. Thus, the nurse only becomes aware of the diagnosis of the virus if the person living with HIV reports it. Such isolation tends to make it impossible for nurses to provide more proximal and integral care – according to the precept of the SUS – due to the lack of knowledge of the broad phases of life of the person living with HIV.

> “We know the people who have HIV here at BHU because some tell us, or were diagnosed here. But there are several other HIV-positive patients who are followed up at the specialized outpatient clinic and there is no communication with BHU. The specialized outpatient records are kept there..” (N13)

The impossibility of accessing the electronic records of people living with HIV, monitoring adherence or maintaining contact with these people who are treated in specialized services is a point of frustration among professionals, who feel isolated from the care network.

> “If a BHU healthcare professional has a significant need for information on a clinical issue regarding a person with HIV, they have to request it from the specialized outpatient clinic coordinator through official documents; it's quite bureaucratic. BHU healthcare professionals don't have access to these people's medical records, but this would be useful in the system. BHU could access the records to determine whether the person is following the follow-up there, whether there is continuity, and truly basic questions.”(N2)

Despite the gap between services, there is an intention among nurses to access the information of this population to promote continuous and integrated care. Nonetheless, access tends to be surrounded by bureaucracies that eventually generate withdrawal, despite declared need.

In addition to this, the professionals themselves, faced with the overload and the perception of vulnerability of the patient to prejudice, adopt distancing as a protection strategy. Direct referral to the outpatient clinic is often an ambiguous gesture: while preserving the confidentiality of the user, it limits the bond and avoids facing the stigma in the daily life of the BHU.

> “We meet a huge demand here... if we take responsibility for this, they {people living with HIV} will be the ones who will be harmed.” (N7)

> “People with HIV know that the specialized outpatient clinic is a restricted place, and this leads them to seek out the service. Many of them don't want a neighbor or friend to know about their status.”(N3)

In this track, report concern about the possible reflections of the situation to the intimate living environment of these people, regarding exposure and lack of professional ethics.

> "workmates {health professionals at BHU} talk in the hallways that so-and-so has been diagnosed with HIV. Look, this {decentralization} is all a theory that guides practice, but it doesn't happen because the patient is very unprotected {in terms of confidentiality}."(N6).

Care, in this context, is disconnected from the principle of longitudinality, emptying the accompanying power that BHU can offer to PLWHA.

Taking care of what one has: overload as an obstacle to listening and bonding

Work overload in PHC was referred to as a limiting factor for care. Several nurses experience HIV testing as a complex, laborious, difficult and even bureaucratic phenomenon, although each step is highly recommended by the Ministry of Health (MH).

> "The rapid test is very laborious, it takes too long to report, I can't see a large number of patients, it's very laborious, so I can't see them, I do one patient per hour, it's a lot of work"(N9)

Professionals reported the impossibility of performing testing on demand, lack of time for adequate advice are questions noted in the speeches. The exhausting daily life imposes choices that directly affect quality of care.

> "Nurses can't handle this population; it's very complicated. Rapid testing takes a lot of time; you have to report, explain, and refer patients. I do the rapid testing, but I'm a clinical nurse, not an ESF nurse. I don't know when I'll have time to do the rapid testing at BHU. It's calm right now, I can do the testing, but not often. There's a lot of demand within the unit, and we already do a lot of things at BHU."(N4)

The lack of financial incentives in the primary health sector, according to nurses, has a direct impact on the ability to absorb demand from people living with HIV.

> "Decentralization in this state puts patients through horrible mental suffering. It doesn't work, it's cruel. We don't have a permanent gynecologist; we have a gynecologist who comes on Tuesdays to see only medium-risk pregnancies. The person who sees is a general practitioner on my team. The psychologist has a waiting list of over 80 patients. The municipality doesn't invest in hiring professionals." (N6).

Furthermore, nurses feel the lack of a protocol, flow or model for offering actions, developed by municipal management to standardize care.

> "Sometimes protocols change and BHU doesn't even know about them. They (management) could create a protocol for the entire municipality and make it available. The ones I have here are very old, most of them are already 10 years old.." (N12).

Waiting is not enough: desire for training, support and reorganization of care

Nurses reveal, in their speeches, a recurring feeling of unpreparedness and institutional helplessness before the demands of care to people living with HIV in PHC.

> "{management} would need to develop ongoing training and ongoing updates involving all sectors. HIV is often a taboo topic, both for those who deal with it, such as healthcare professionals, and for the general public." (N13)

What is evident in the narratives is a structural gap between public policy and daily practice, in which responsibility for care is assigned to professionals, but without being guaranteed adequate conditions for its implementation.

> "I completed rapid testing training at another health region many years ago. When I came here, since I already had training, they said I didn't need to do it, that it was a one-time thing. But I think there should be an update on treatments, approaches, new approaches, perhaps legislation. Because we get into a routine and lose our grip." (N1)

The professional experience is marked by technical insecurity, absence of updated protocols and lack of training spaces that guide them regarding current guidelines and the most appropriate clinical practices.

> "I think it could be improved. They should work more with the professionals who are on the front line {providing care}, because those within the health department don't have the same perspective I have when I'm working. The person [in management] has already received training on HIV, so why would they pass it on to the department? It has to be for the employees on the front line, and that's very little."(N8)

The demand for standardized protocols and integrated flows reflects the need to transform PHC into a legitimate, safe and prepared space to accompany longitudinally people with HIV, breaking with the technical and symbolic isolation experienced by professionals.

DISCUSSION

Listening to nurses revealed silent dimensions of care that often remain hidden under the normative assistance. Their voices echo uncertainties, fears and limits experienced in the concreteness of practice, revealing a scenario in which the decentralization of care to people living with HIV is not configured as a mere technical policy, but as a movement that tensions subjectivities, structures and ways of caring.

The introduction of rapid HIV testing in PHC has been an important milestone in the opportunity for diagnosis(14). Considering the capillarity that PHC has as its basic principle, it is believed that the decentralization of attention to HIV, in addition to the offer of rapid test on demand, is favorable to the qualification of care for people living with HIV, regarding the ease of monitoring treatment, integrality in the attention to demands, as well as implementation of strategies for prevention of transmission(15).

However, the decentralization proposal, although anchored in the expansion of access and capillarity of PHC, imposes challenges that go beyond the operationalization of the rapid test. It requires institutional redesign, agreement between services, reorganization of time and work, and above all, qualified listening. The approach between professional and user, desired as an ethical element of care, may paradoxically turn out to be a source of embarrassment, insecurity and even withdrawal, in view of the stigma still present around HIV(14,15,6).

Published studies point to the strategies used to implement decentralization of care in order to operationalize and favor the reorganization of assistance to people living with HIV(16-19). They demonstrate that decentralized care brings together professionals and people living with HIV and develops strategic routines to systematize care and follow-up, not only between the nurse, but the multidisciplinary team of PHC(16-19). The findings of this study dialogue with national and international literature to show that the success of decentralization does not lie in the simple transfer of responsibilities, but in the construction of sustainable institutional links and in strengthening the ethical and technical autonomy of PHC professionals.

Nevertheless, for the nurses in this study, the process of decentralization of HIV care is still a very recent issue and sometimes even unknown. There was a lack of training and difficulty in following the recommendations to current updates related to HIV by nurses from BHU. The integral care, in this context, emerges as an ideal that requires conditions of existence. The overload, the absence of regular training, the lack of well-defined flows and the disconnection with specialized services make the exercise of this care more rhetorical than effective (19,20).

The professionals express a desire for an integrated network, accessible protocols, spaces for continuous training and, especially, shared support. However, the overload of work combined with the lack of training and support from specialized services have an impact on the decentralization process(14,15). The various responsibilities of nurses in PHC are considered obstacles that strain the decentralization process, influencing the maintenance of a strictly specialized HIV care logic.

Health professionals are responsible for providing basic guidance on HIV treatment, in accordance with their particularities and needs, in order to reduce the anxieties and insecurities that may arise during this period. However, it is common for health professionals to transfer this responsibility directly to the specialized service (15,18). It is not a refusal to care, but a displacement of care: from the territory of proximity to the shelter of the specialty. The statements indicate that the absence is not negligence, but protection – of the patient, the professional, and the bond itself that could be compromised by failures in structure, confidentiality and clinical support.

The gap in knowledge about HIV among health professionals may contribute to the lack of responsibility for the care of this population in PHC, resulting in late diagnosis, delay in the beginning of treatment, in the progression of infection to AIDS, and the maintenance of collective transmission of the virus(3,6,19,20).

Moreover, nurses considered the geographic location of PHC services as a factor that may impair attention. The experience of stigma, both real and presumed, crosses the discourses and strains the possibilities of longitudinal follow-up of

PLWHA. Ethical care requires more than technical knowledge – it requires sensitive positioning in the face of alterity and social vulnerabilities(19,20,22,23). PHC, as a space for community coexistence, needs to be prepared not only with inputs and flows, but with listening, ethics and commitment(18,21).

Thus, it is understood that the decentralization of HIV care must be continuously debated, reformulated and built collectively. Professionals do not oppose the policy, but rather the absence of conditions that support its implementation. Therefore, institutional planning must take into account the ways of being, feeling and acting of those who live care in their practice. It is not just a matter of expanding access, but of ensuring that the encounter between professional and user is legitimate, protected and committed to human dignity(19,20,23).

Study limitations

This study sheds light on unique experiences of nurses working in BHU, but recognizes as a limitation the professional cut adopted. By favoring the listening of nurses, it is restricted to the multiplicity of looks and knowledge that also cross the care of people living with HIV. The interprofessional practice, an essential characteristic of care in PHC, brings together other subjects – doctors, community agents, pharmacists, psychologists – whose experiences could enrich the understanding of the phenomenon investigated. Thus, it is understood that the expansion of the voices heard is a possible and necessary way to deepen the texture of shared care.

Contributions for practice

By revealing the senses experienced by nurses in the conduct of care to PLWHA, this study offers concrete subsidies to the management of the UHS for (re)thinking strategies that promote not only the technical decentralization of care, but its ethical, affective and institutional viability. The findings indicate that strengthening listening, valuing local singularities and building intersectoral arrangements are powerful ways to ensure continuity, confidentiality and integrality of attention.

More than reinforcing the importance of decentralization as a guideline, this study invites practice to humanize itself. Suggests that training actions should not be punctual or imposed, but continuous, dialogical and contextualized. It is reaffirmed that ethical care, especially in the face of the stigma that still rests on HIV, requires presence, empathy and networking.

Therefore, by making visible the challenges and powers experienced in the daily life of services, this research aims to contribute to the construction of public policies sensitive to the experience, which consider professionals as active subjects in the process of transformation of health care.

FINAL THOUGHTS

The experience of nurses working in Basic Health Units reveals a care built between presences and absences, knowledge and uncertainties, commitments and silences. Being a nurse in the context of decentralization of care to people living with HIV is often experiencing the burden of responsibility without the support of necessary institutional conditions. It is acting in an ethical and affective field, where the social stigma still inhabits the lines of the meetings and where the unpreparedness, more than an individual failure, expresses itself as a symptom of a care still in structuring.

The senses built in the daily life of nurses point out that caring, in this scenario, is crossed by insecurities, training gaps and organizational difficulties — but also by a desire to do differently, to accompany with listening, to welcome with presence. Thus, the findings of this study not only describe obstacles, but also enunciate some outstanding needs: to build a network that recognizes BHU professionals as involved subjects, and not just executors; to promote training that considers the experience, and not only the prescription; to develop strategies and policies that consider and integrate technical care and human sensitivity.

Therefore, the results affirm that being a nurse in the care of people living with HIV in the BHU space is an experience of daily tensions that reveal both the fragilities of politics and the power of bonds. It is a care that requires time, space, listening and shared commitment. Which requires not only skills and flows, but also ethics, confidence and courage to sustain the encounter with the other in its vulnerability. That this listening to the lived can, then, sustain more sensitive management processes, policies more rooted in the reality of services and practices more aligned with the dignity of those who care and who are cared for.

TRANSFERÊNCIA DO CUIDADO EM HIV PARA A ATENÇÃO PRIMÁRIA: A PERSPECTIVA DE ENFERMEIROS

RESUMO

Objetivo: compreender a vivência de ser enfermeiro na Unidade Básica de Saúde no cuidado às pessoas vivendo com HIV, considerando os sentidos construídos no cotidiano da prática assistencial. **Método:** estudo descritivo, com abordagem fenomenológica, realizado com enfermeiros de um município do sul do Brasil, entre setembro e novembro de 2023. A análise dos discursos ocorreu baseando-se na Análise Qualitativa do Fenômeno Situado: compreensão de sentidos e aproximação, identificando as unidades de significado, que foram ao fim agrupadas em categorias. **Resultados:** Os discursos dos 13 enfermeiros revelaram quatro categorias temáticas. A primeira evidencia a tensão vivida no cuidado às pessoas com HIV. A segunda aponta a ruptura do vínculo entre UBS e usuário, marcada pelo sigilo, estigma e distanciamento protetivo. A terceira destaca a sobrecarga e a ausência de suporte como limitações. A quarta expressa o desejo por capacitação e apoio institucional evidenciando o descompasso entre as diretrizes e a realidade profissional. **Considerações finais:** Ser enfermeiro no cuidado às pessoas vivendo com HIV na UBS envolve tensões éticas, insegurança e falta de apoio, mas também desejo por vínculo e reorganização do cuidado. Os achados apontam a necessidade de políticas mais sensíveis e integradas à realidade dos serviços.

Palavras-chave: HIV. Teste de HIV. Política de Saúde. Atenção Primária à Saúde. Enfermagem de Saúde Pública.

TRANSFERENCIA DEL CUIDADO EN VIH PARA LA ATENCIÓN PRIMARIA: LA PERSPECTIVA DE ENFERMEROS

RESUMEN

Objetivo: comprender la experiencia de ser enfermero en la Unidad Básica de Salud en el cuidado a las personas que viven con VIH, considerando los sentidos construidos en la cotidianidad de la práctica asistencial. **Método**: estudio descriptivo, con enfoque fenomenológico, realizado con enfermeros de un municipio del sur de Brasil, entre septiembre y noviembre de 2023. El análisis de los discursos se realizó basándose en el Análisis Cualitativo del Fenómeno Situado: comprensión de sentidos y aproximación, identificando las unidades de significado, queal final fueron agrupadas en categorías. **Resultados**: los discursos de los 13 enfermeros revelaron cuatro categorías temáticas. La primera evidencia la tensión vivida en el cuidado a las personas con VIH. La segunda señala la ruptura del vínculo entre UBS y usuario, caracterizada por el sigilo, estigma y distanciamiento protector. La tercera destaca la sobrecarga y la ausencia de soporte como limitaciones. La cuarta expresa el deseo de capacitación y apoyo institucional, evidenciando el desajuste entre las directrices y la realidad profesional. **Consideraciones finales**: ser enfermero en el cuidado de las personas que viven con VIH en la UBS implica tensiones éticas, inseguridad y falta de apoyo, pero también deseo por vínculo y reorganización del cuidado. Los hallazgos señalan la necesidad de políticas más sensibles e integradas a la realidad de los servicios.

Palabras clave: VIH. Prueba de VIH. Política de Salud. Atención Primaria de Salud. Enfermería en Salud Pública.

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