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RESEARCH

SOCIAL REPRESENTATIONS OF BASIC CARE WORKERS ABOUT THE RAPID TEST

REPRESENTAÇÕES SOCIAIS DE TRABALHADORES DA ATENÇÃO BÁSICA ACERCA DO TESTE RÁPIDO

REPRESENTACIONES SOCIALES DE TRABAJADORES DE ATENCIÓN BÁSICA SOBRE LA PRUEBA RÁPIDA

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ABSTRACT

Objective: to understand the content and structure of social representations for health professionals about the rapid test for the detection of sexually transmitted infections in a municipality in Bahia. **Method:** qualitative research based on the theory of social representations, in its structural approach, carried out in 12 basic health units. 37 higher-level health workers participated. Data collection was performed through a script that included questions related to the professional characterization, plus the inductive expression rapid test. The corpus was organized and processed with the help of the software *Ensemble de Programm Espermettant Lanalyse des Evocations*. **Results:** the possible constituent elements of the central core of the representation for these workers, in direct order, were represented by the term HIV and, instead, by fear, HIV, diseases and agility. The senses attributed to the fast test, disclosed in the central core, show discrepancy – considering the direct order and the substitution – among the representations and, in a certain measure, they characterize them as distinct representations.

Keywords: Point-of-Care Testing; Health Personnel; Primary Health Care; Semantics.

RESUMO

Objetivo: *apreender o conteúdo e a estrutura das representações sociais de profissionais de saúde sobre o teste rápido para detecção de infecções sexualmente transmissíveis em um município baiano.* ***Método:*** *pesquisa qualitativa fundamentada na teoria das representações sociais, em sua abordagem estrutural, realizado em 12 unidades básicas de saúde. Participaram 37 trabalhadores de saúde de nível superior. A coleta de dados foi realizada por meio de um roteiro que comportou questões relacionadas à caracterização profissional, acrescido da expressão indutora teste rápido. O corpus foi organizado e processado com auxílio do software Ensemble de programm espermettant lanalyse des evocations.* ***Resultados:*** *os possíveis elementos constituintes do núcleo central da representação desses trabalhadores, em ordem direta, foram representados pelo termo HIV e, em substituição, por medo, HIV, doenças e agilidade. Os sentidos atribuídos ao teste rápido, revelados no núcleo central, mostram discrepância – considerando a ordem direta e a substituição – entre as representações e, em certa medida, as caracterizam como representações distintas.*

Palavras-chave: *Testes Imediatos; Pessoal de Saúde; Atenção Primária à Saúde; Semântica.*

RESUMEN

Objetivo: *analizar el contenido y la estructura de las representaciones sociales de profesionales de salud sobre la prueba rápida para detectar infecciones de transmisión sexual en un municipio de Bahía.* ***Método:*** *investigación cualitativa basada en la teoría de las representaciones sociales, en su enfoque estructural, realizado en 12 unidades básicas de salud. Participaron 37 trabajadores de salud de nivel superior. La recogida de datos fue realizada por medio de un cuestionario con preguntas sobre la caracterización profesional y la expresión inductora prueba rápida. El corpus fue organizado y procesado con ayuda del software Ensemble de programm espermettant lanalyse des evocations.* ***Resultados:*** *los posibles elementos constituyentes del núcleo central de la representación de dichos trabajadores, en orden directo, fueron representados por el término VIH y, en sustitución, por miedo, VIH, enfermedades y*

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agilidad. Los sentidos atribuidos a la prueba rápida, revelados en el núcleo central, muestran discrepancia – considerando el orden directo y la sustitución – entre las representaciones y, en cierta medida, las caracterizan como representaciones distintas.

Palabras clave: *Pruebas en el Punto de Atención; Personal de Salud; Atención Primaria de Salud; Semántica.*

INTRODUCTION

The acquired immunodeficiency syndrome (AIDS) epidemic remains relevant to public health because it shows challenges in coverage and access to comprehensive and qualified prevention and treatment services. In the year 2017, 16,371 new cases of human immunodeficiency virus (HIV) infection were reported in Brazil.[1] In the municipality under study, the *Centro de Testagem e Aconselhamento* (CTA) registered in 2014 about 430 cases of HIV/AIDS, these being more prevalent among people who declared themselves to be men. The municipality has records regarding seven confirmed cases of hepatitis B by sexual transmission and six cases of AIDS in 2012, as well as two occurrences of syphilis in pregnant women in 2010.[2]

The changes occurring in the contemporary Brazilian sexual behaviors, such as the increase in casual sex and the reduction in using condoms, present a challenging scenario for health professionals in managing sexually transmitted infections (STIs), as well as the management, especially, regarding planning and acquiring inputs. The *Ministério da Saúde* (MS) has expressed its concern about the availability of rapid tests, recognizing the need for this action to take place in a way that guarantees the right to citizenship and respect for the human being.[3]

Technological apparatuses have priority in health, to the detriment of the interpersonal relationship, causing distancing of human suffering (historical origin of the curative practices), the disqualification of the sick person and the valuation of the disease.[4] Thus, to recover the integrality of users of these services, recognizing them as active agents in decision-making regarding health actions, implies the recognition of their subjectivities and singularities in interaction with the professional that attends them.

On the part of these services, consideration should be given to proposing effective solutions, in view of the composition of the teams or even the lack of investment in professional qualification, through continuing education. From this angle, faced with these circumstances, the professional may feel helpless and often does not know how to proceed, which represents a significant factor of attrition and even psychic suffering in the exercise of their *praxis*.[5]

The network of services for STI/HIV is made up by the CTAs, *Unidade Básica de Saúde* (UBS), *Unidade de Saúde da Família* (USF) and medium and high complexity services. In any situation where counseling and rapid test offerings occur, in this network, the key is that privacy, secrecy and confidentiality are preserved.[6]

In the dispensation of primary health care there are many areas of intervention, in which it is not only important to respond to the emotional needs of users, but also to use the advice to facilitate the change of behaviors and attitudes aiming to minimizing the risks for infection, such as STI/HIV.[7] It is in the constant search for alternatives to this confrontation that the answers are not presented ready and / or finished, but consolidated in the joint effort of involved actors, primordial elements in this process.

In this aspect, the basic care teams have an excellent role in the diagnosis and accompaniment on the diagnosed people – with symptomatology and/or not – as for the STI/HIV, as a routine for care and ethical and professional duty. It is essential to recognize the stress faced by these professionals in the day-to-day work of the service since they deal daily with difficult situations such as the delivery of results considered "reagent" for HIV serological tests, marital crises, involvement with alcohol and other drugs, among others. They often do not have the personal resources to propose actions and/or intervene in a resolutive manner, and it is fundamental to recognize that the support and supervision on the part of these professionals need to be guaranteed in the institutional routine.[8]

Therefore, when discussing the clinical management of STI/HIV, focusing on the challenges to effective prophylaxis and minimizing risks and spreading, it is expected that health professionals will be able to reflect on their practice and evaluate the possible limitations as well as the working conditions offered by the health system, where professionals and users of the respective services are inserted. A humanistic approach in which subjectivities should be valued must exist so that this environment, which is so significant for education and prophylaxis created by the basic unit, behaves in accordance with the prevention stages advocated by the *Ministério da Saúde*.

Considering the socio-cultural dimensions that involve the counseling and diagnosis of STI/HIV and the specificities of the professional practice in basic care, it is defended that the studied subject fits as object for social representations. The theory of social representations (SRT) can be defined as a set of articulated concepts that originate in social practices and group diversities whose functions are to give meaning to the social reality, to produce identities, to organize the communications and to guide the conducts.[9]

It is understood as a theoretical construction developed by the socio-psychological current, called social thought, which is dedicated to the investigation of cognitive processes and constructs. As a theory, it proposes socio-psychological analysis, in the sense of providing a broader understanding of the phenomena of social interaction.[10] The SRT is a scientific study with common sense, considering that knowledge varies according

to specific insertions within a framework of social relations and that will imply a group identity that will guide social practices.[10]

This research was based on SRT's structural approach, developed by Jean-Claude Abric. The central core theory (CCT), also known as structural approach, has complementary elements to SRT, since it deals with organized and structured cognitive content. In this way, the content of the representation is constituted from a central and an other peripheral system, with distinct features and functions. This structural organization has a hierarchical nature, that is, its systems of cognitions are interconnected and differ in their natures and functions relative to the representation.[11]

This study for Nursing and Health becomes important due to the narrowing theory and professional practice. In this sense, it may collaborate with the daily activities of nurses who work in basic health units, especially regarding the approach of people living with STI/HIV. It is also justified by the interest in observing and understanding how is the practice of rapid testing, carried out by health professionals, the risks for infection and the possibility of adherence to the treatment of STI/HIV have been taking place in the basic care as another strategy for action focused on health education.

Therefore, understanding the strategy that guides the implementation and counseling of the rapid test, the difficulties and representations of professionals working in basic care services in the process of coping with the epidemic can contribute to the transformation of this reality. To the extent that it allows for reconstructing the way of thinking and doing of the managers and workers who participate directly in the care, it can have positive and significant implications for the users that guarantee the principles of universality, equity and integrality of the care, that guide the *Sistema Ùnico de Saúde* (SUS).

Thus, this study aimed to understand the content and structure of social representations for health professionals about the rapid test for detecting sexually transmitted infections in a municipality in Bahia.

METHOD

Descriptive and exploratory qualitative research, grounded in the SRT. A total of 37 university-level professionals (nurses, physicians, pharmacists, dentists and social workers) took part in the study, 12 UBS in the municipality of *Senhor do Bonfim-Bahia*, among the 42 professionals who make up the basic care framework. As inclusion criteria, the professionals should be 18 years old or older and be directly involved in the care of persons with STI/HIV (37); as criteria for exclusion, to be on vacation or license at the time of data collection (five).

In order to reach the content and structure of social representation, one used word evocation. The test of free evocations or associations allows to restrict the difficulties and limits of the discursive expressions, commonly used in the researches for social representations.[12] The answers derived from free association, that is, short phrases or expressions, are provided from an inductive stimulus, which is usually the term that refers to social representation (SR) object.[13] The evocation data, using the *Teste de Associação Livre da Palavra* (TALP) with response to the "rapid test" inductive expression, were collected individually in each of the UBS/USF and recorded in digital medium after signing on the FICF.

The data from the TALP were processed in the software *Ensemble de Programmes Permettantl'Analyse de Évocations* (EVOC) version 2005, which allowed for prototypical analysis and the structural characterization of social representation. It should be noted that, in addition to the constituent elements of the representation at issue, it was possible to compare the results among the corpora of the two normative contexts (in normal situation and substitution situation), for the evoked terms. Statistical analysis made possible by the software (minimum and average frequencies and average evocation order) resulted in the frame of four houses for each of these contexts. The CCT, in social representations, can be conceived as a system formed by two types of elements: a central core and the peripheral system.[14]

The analysis of the structure, from the central core of the representations, was made using the EVOC. These computational tools increase the validity of the study by admitting the possibility of procedures for transferring the results to other studies in the case of lexical, semantic, similarity and difference analyses.[15]

For collecting socio-professional data, a script was elaborated consisting of questions related to the profile of the interviewee: gender, age, time as qualified professional, length of service in the municipality, type of employment relationship; and also on the work developed with the clients, whether or not they have STI/HIV: teamwork, theoretical/practice in service, communication, clinical management and educational activities.

The analysis of data regarding socio-professional characterization and practices related to the care of persons with STI/HIV was tabulated by the program Microsoft Excel, with some of the results being submitted in absolute and relative frequencies. The ethical aspects were respected in all the research stages, according to Resolution of the *Conselho Nacional de Saúde* No. 466/12, and the project was approved by the *Comitê de Ética em Pesquisa da Universidade do Estado da Bahia*, CAAE 53996816.4.0000.0057.

RESULTS AND DISCUSSION

The presentation and discussion of socio-professional data and TALP will take place jointly. As for the demographic characteristics, 23 participants were older than 35 years, 29 were female, and 33 of them had specialist degree and two with doctorate. Among the socio-professional data, the activities carried out in

the service and aimed specifically at the care of the person with STI/HIV stand out. The Table 1 consolidates these findings.

Table 1 - Activities developed by health professionals. *Senhor do Bonfim*, 2018

Activity	n (%)
Reception and counseling	17(45.9%)
Individual / collective pre-test or post-test counseling	17(45.9%)
Offer of examination	20(54.0%)
Realization of rapid test	12(32.4%)
Consultation/care	23(62.1%)
Treatment and support for the partner or family	13(35.1%)
Educational activity	26(70.2%)
Epidemiological notification	15(40.5%)
Distribution of condoms	18(48.6%)

Source: research data, *Senhor do Bonfim-BA*, 2018.

Based on Table 1, the educational activity, consultation/care, offer of examination and distribution of condoms are actions performed by about 50% of the study participants; and the rapid test by 32%. It is worth mentioning that the rapid tests are those whose execution, result reading and interpretation are done in 30 minutes maximum. In addition, they are easy to execute and do not require a laboratory structure, only training of professionals, and are recommended for on-site testing.[6]

In the data from TALP, in response to the inducer term "rapid test" in direct order, the 37 professionals evoked 201 terms with mean evoked order (MEO) of 2.8, on a scale of 1 to 5. For the same inducer term, but in substitution situation (what I imagine that the other one thinks), the professionals evoked 164 terms, maintaining the same MEO. When the evocations whose frequency was equal to or less than three were neglected, one established for the direct order the average evocation frequency as equal to nine, and for the substitution, equal to six. The combined analysis of these data resulted in Table 2 as representative of the four-house table provided by the software EVOC.

Table 2 shows, for the term "rapid test", the four quadrants for each of the drawn up situations (direct order and substitution). The first quadrant is located on the upper left axis and is also referred to as the central core (CC); the second on the upper right axis; the third in the lower left; and the fourth at the lower right. The contents of the table of four houses are described below, which will be discussed in the same order.

Table 2 - Frame of four houses, the inductive expression "rapid test", in direct order and in substitution (n= 37). *Senhor do Bonfim*, 2018

Central core						Near peripheral system					
Direct Order			Replacement			Direct Order			Replacement		
F ≥ 9	MOE < 2.8		F ≥ 6	MOE <2.8		F ≥ 9	MOE ≥ 2.8		F ≥ 6	MOE ≥ 2.8	
HIV	9	1.333	Fear	23	1.826	Agility	16	2.938	STI	6	2.833
			HIV	12	2.000	Prevention	9	3.333	Prejudice	6	3.000
						Diseases	9	2.000	Embaressment	6	2.833
						Agility	8	2.625			
Near peripheral system						Distant peripheral system					
F < 9	MOE < 2.8		F < 6	MOE < 2.8		F < 9	MOE ≥ 2.8		F ≥ 6	MOE ≥2.8	
Information	7	2.429	Smartness	4	2.750	Treatment	6	3.667	Trustworthy	5	3.000
Syphilis	6	2.667				Health	5	3.600	Treatment	5	3.800
Diagnosis	5	2.000				Care	4	3.750	Doubt	4	3.000
Smartness	5	2.400				Zika	4	4.250	Prevention	4	4.500
User-embracement	4	2.750				Diseases	3	3.333	Diagnosis	3	3.333
Assurance	4	2.250				STI	3	3.000	Insecurity	3	3.000
Trustworthy	4	2.250				Important	3	3.333			
Pregnant	4	2.000				Insecurity	3	3.000			
Hepatitis	4	2.750				Practicality	3	3.000			
Result	4	2.750									
Screening	3	2.333									
Detection	3	1.333									
Fear	3	2.667									

Source: research data, *Senhor do Bonfim-BA*, 2018.

In the upper left quadrant, the elements likely to constitute the CC of the social representation for the professionals in direct order are represented by a single term, HIV. By positioning themselves as the other, they appear as a constituent of the CC "fear, HIV, illness, agility".

The CCs in Table 2 call attention, since that the term HIV, for the direct order, is the most important component according to its hierarchy. And it shows contrast among professionals, since that, when imagining what the other one experiences, the component with the highest hierarchy is "fear". It is possible that elements that appear in the core quadrant, often much larger than the other components, are central to the representation.[16] When imagining that they have autonomy to "speak for the other one", the studied workers reveal in the element "fear", evoked 23 times (67%), a possible central element in the representation studied. Thus, it is possible to infer that the presence of "fear" element as a constituent of the CC may be translating a prejudice as a guideline for SR.

However, in suggesting what best defines HIV/AIDS, the most pointed out responses by the participants were: the need for protective measures to care for (22), the need for health guidelines (21), prejudice (15) and fear feelings (11). A definition of HIV/AIDS is marked by "risk, fear and prejudice", elements that support the central core content by imagining the position/situation of the other one.

The term HIV, as a direct CC element, denotes how historically the AIDS epidemic has boosted technological advances, and although the rapid tests cover other STIs (syphilis, hepatitis B and hepatitis C), they remain invisible in the central core of the studied representation.

The sense attributed to a given object by the subject comes from the information that continually arises from its practice and from its relations.[17] Considering the CCs presented, it can be inferred that the sense attributed to what one imagines the other thinks reveals representational elements that circulate in the social and practical relations that accompany AIDS since its appearance in the 1980s.[4]

Regarding their typology, the social representations found in this study can be classified as emancipatory because they have the characteristics of being produced in/by intergroup relations that allow to differentiate the divergent groups.[18]

The term HIV is the element found in both the central core, however, insofar as the professional imagines talking about the other one, the term acquires more hierarchy and less prominence. Analyzing the set of terms that constitute the central core representation, it can be inferred that this representation means that its contextualization takes place both in the field of reified knowledge and hegemonic representations.

Thus, it is possible to affirm that the subjects in this study attribute to the object a sense-related complexity, when they have the possibility for speaking of somebody else being non-provided with its censorship, incurring into value judgment. This representation covers both aspects related to the biological and psychological dimensions, revealing a similarity with the scientific knowledge of professionalization in the health area, as well as social aspects, which reveal the meaning attributed by society in general.[15]

The offer to the rapid test has expanded the access to the HIV diagnosis in the territory, however, it creates situations of embarrassment in going to the health unit, due to the stigma that these infections carry.[19] Social representations are both normative, inserting objects into social models, as well as prescriptive, serving as a guide for social actions and relations.[10]

The terms evidenced in the core, constituent of the representation of other ones, allow for references to effects (cause/illness) and indicate technological progress translated into agility, considering the temporal issue demonstrated in the result. Thus, the figurative core of SR after modeling approaches and moves away from the current AIDS scenario, which is being conceived as a socially acceptable phenomenon due to technological advances, without distancing itself from the onset of the epidemic.

When dealing with SR on AIDS, AIDS representations are based on domination ideologies, including those related to colonialism and heterosexism, identifying that hegemonic representations in any field, are at the service of power relations. The findings found in this study point out to similar foundations for caregivers of the person who needs to perform rapid tests. These results are in line with other studies that sought to know the social representations and HIV/AIDS.[19-20]

The other words evoked in direct order, found in the upper right quadrant in Table 2, referred to as proximal periphery, are agility and prevention; and for the evocations in substitution, STD, prejudice and shame. It is observed that the near peripheries reveal structurally professional attributions (prevention and diagnostic agility) and concern about the complex and relatively new social phenomena (prejudice and shame). It is inferred, therefore, that there is a distance between the groups regarding the behavioral and psycho-affective attributes of the representation, evidenced in the extent to which the professionals distance themselves from their praxis, when imagining speaking for the other one.

It is noteworthy that the professionals, when asked about the main sources of HIV/AIDS information used, cite: sites in general on the internet (28), technical manuals (25) and conversations in the professional daily routine (19). The "Invisibility is not due to any lack of information caused by someone's vision",[10] because, if one accepts facts that are basic without discussion, they will not be able to transpose reality.

It is worth pointing out that AID's issue, involves health professionals, both in their private life and as workers. As a

health professional, due to the conviviality with the consequences of the disease, they derive a type of representation, still found today, in which AIDS is strongly localized in its association with shame and prejudice.[19,21]

In the third quadrant, also considered close periphery, the elements submitted here are called contrast elements and explain the existence of a certain representational subgroup. In their direct order, the terms information, diagnosis, reception, reliability, outcome, screening and detection confirm, to a certain extent, the differences when the same participants disguise their social role as professional and evoke only the term cleverness, which already was mentioned by the central core of the representation.

Social representations play essential roles in the dynamics of social practices and relations.[11] These functions are referred to by Moscovici as: knowledge, identity, orientation and justifying. RS, besides understanding and explaining, define the identity of a group, directly implying the process of socialization of its participants.[20] Thus, the cleverness element present in the third quadrant in both situations carries positive aspects of the rapid test, and possibly has been incorporated into a self-care sense-promoting perspective associated with the dynamics of modern life. And the terms syphilis, pregnant woman and hepatitis go back to similarity with other diagnostic tests offered in the public health network.

In the fourth quadrant, or distant periphery, the evoked terms have low frequency and high MEO, being evoked by a small number of participants. In Table 2, the terms treatment, health, care, zika, diseases, STD, important, insecurity and practicality, that have affinity with the proper health language, appear in direct order. In this sense, it is understood that the diseases may be controlled/treated based on information and guidance and resemble the terms mentioned in the other one situation as "treatment, trust, doubt, prevention, diagnosis and insecurity". The data are in agreement with the theoretical-methodological aspects related to the SR studies.

Another relevant focus for discussion, given the fourth quadrant content, are the terms ignorance and suffering, which may be related to the structural and/or organizational conditions in the UBS/USF or even the wear and tear in the work. The SR and occupational risk in AIDS suggest representations of health workers not only of the order of scientific knowledge, but also psychosocially constructed and integrated into their daily lives.[22]

The tables submitted in this study differ in their structural configurations and homogeneity. The social representations of the TALP applied in direct order show more dispersed configurations, showing redundancy of themes by the variety of terms, being considered heterogeneous representations, and incorporate technical and psychosocial aspects associated to a "politically correct discourse". For the representations originating from the situation of substitution by others, the configuration is coherent, synthetic, with the information on few main themes, characterized by the focus on negative aspects of RS, given that, in evoking, they were given the opportunity to unbind aspects related to morality.

This research has significant scope regarding the field and participants with respect to their production. However, its limitation in a single municipality does not allow for generalizations regarding the addressed topic. Nevertheless, the results are significant for analyzing the offering of a technology recently implemented in the basic care network and can be used in theoretical comparisons related to the them with other pertaining groups. In addition, the evidence of persistent negative feelings about the rapid test reveals worrying aspects of social representations possibly linked to the contexts and experiences of the onset of the epidemic that need to be overcome in order to improve care for people living with HIV.

FINAL CONSIDERATIONS

The main evidence of the study refers to what was common in the representations in both proposed situations. When assigning the HIV test function to the rapid test as the central element for constituting the two frames, the representations are characterized as being hegemonic. However, when assuming the speech of the other one, the professionals unveil one more representational content - fear - as attitudinal element evolving the care to the people with HIV. Thus, their representations resemble representations at the beginning of the epidemic, emphasizing the permanence of fear for contracting HIV through labor practices. It should be considered that this representation can also have an impact on the health care practice of people seeking basic care services for the early diagnosis on HIV/hepatitis/syphilis.

As for the aspects evidenced in the central core, the sense attributed to the rapid test disclosed a discrepancy - considering the direct order and the substitution - among the representations and, in certain measure, they characterize them as distinct representations. The findings reveal that, regardless of advances in health, regarding the management of the rapid test, fear still persists. Therefore, it is relevant to strengthen multi-intertransdisciplinary actions for discussions on this topic in the qualifications and in-service training, aiming at moments of information/experience exchange and explication of doubts that lead to ruptures of stereotypes and favor integral care.

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