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Social representations of nurses on the field health

Representaciones sociales de enfermeras en la salud de campo

Representações sociais de enfermeiras sobre a saúde do campo

ABSTRACT
Objective: to analyze the social representations of nurses in the Family Health Strategy on rural health. Method: this is an exploratory, qualitative study, based on the theory of social representations, carried out with 11 nurses who work in family health in rural communities. For data collection, semi-structured interviews were used, for data collection, semi-structured interviews were used, and for organization and processing, the Iramuteq software. We chose to use the similarity tree and the word cloud. Results: the nurses' representations are directly related to the problems and deficiencies experienced in the practice of the service and focus on the population's difficulty in accessing the health unit and services. They recognize the importance of their performance in rural health and dialogical relations and the historical differences between the rural and the urban. Conclusion: the representations are anchored in the health needs of rural populations and demand hard work from the Family Health Strategy.
DESCRIPTORS: Community Health Nursing; Family Health; Rural population; Qualitative research; Nursing.

RESUMEN
Objetivo: analizar las representaciones sociales del enfermero en la Estrategia Salud de la Familia en salud rural. Método: se trata de un estudio exploratorio, cualitativo, basado en la teoría de las representaciones sociales, realizado con 11 enfermeras que trabajan en salud familiar en comunidades rurales. Para la recolección de datos se utilizaron entrevistas semiestructuradas y Para la recogida de datos se utilizaron entrevistas semiestructuradas y para la organización y procesamiento el software Iramuteq. Elegimos utilizar el árbol de similitudes y la nube de palabras. Resultados: las representaciones de las enfermeras están directamente relacionadas con los problemas y necesidades vividas en la práctica del servicio y se enfocan en la dificultad de la población para acceder a la unidad y los servicios de salud. Reconocen la importancia de su desempeño en la salud rural y las relaciones dialógicas y las diferencias históricas entre lo rural y lo urbano. Conclusión: las representaciones están ancladas en las necesidades de salud de las poblaciones rurales y exigen un trabajo arduo a la Estrategia Salud de la Familia.
DESCRIPTORES: Enfermería en Salud comunitária; Salud de la Família; Poblacíón rural; Investigacíon cualitativa; Enfermería.

RESUMO
Objetivo: analisar as representações sociais de enfermeiras da Estratégia de Saúde da Família sobre a saúde do campo. Método: trata-se de estudo exploratório, qualitativo, ancorada na teoria das representações sociais, realizado com 11 enfermeiras que atuam em saúde da família de comunidades rurais. Para coleta de dados utilizou-se entrevista semi-estruturada, e para organização e processamento, o software Iramuteq. Optou-se por utilizar a árvore de similitude e a nuvem de palavras. Resultados: as representações das enfermeiras relaciona-se diretamente com os problemas e carências vivenciados na prática do serviço e centram-se na dificuldade de acesso da população à unidade e serviços de saúde. Reconhecem a importância da sua atuação na saúde do campo e das relações dialógicas e das diferenças históricas entre o rural e o urbano. Conclusão: as representações ancoram-se nas necessidades de saúde de populações rurais e demandam um árduo trabalho da Estratégia de Saúde da Família.
DESCRITORES: Enfermagem em Saúde Comunitária; Saúde da Família; População rural; Pesquisa qualitativa; Enfermagem.

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INTRODUCTION

The role of nurses in the context of Primary Care (PC), in Brazil, was expanded through the implementation of the Community Health Agents Program (Programa de Agentes Comunitários de Saúde - PACS) in 1991, from the perspective of the Primary Health Care (PHC) model. Initially, supported by a territorial logic with the inclusion of customers and health responsibility. [1]

Currently, the Family Health Strategy (FHS) is configured in a restructuring of care centered on the family, understood and perceived in its physical and social environment. This strategy foresees the participation of the community in partnership with the team in the identification of the causes of health problems, the definition of priorities and the assessment of all work, the main focus being on prevention and health promotion actions aimed at intervening in aggravating factors. and obtain a leading role in the face of the challenge of a better quality of life. [2-3]

With the expansion of PC coverage through the FHS, many nurses started to work in units located in rural territories, characterized by the distance from urban centers and by the particularities of the place and its population, which are secularized by public policies. There are countless difficulties encountered in these territories, the following stand out: low education and low wage income, precarious working conditions and labor exploitation, absence of public transport in the most distant areas and work routine at times incompatible with health services. Thus, rural populations continue to have the worst health rates, social determinants and rates of preventive coverage. [4]

The expanded concept of health that includes the collective, the social, the political, the economic and the cultural, conditions so significant in the approach to the health of the rural populations. [5] These are characterized by peoples and communities that have their ways of life, production and social reproduction predominantly related to the land. [6] Such aspects are directly intertwined with the health-disease process, since local peculiarities are factors that should be taken into account, in order to reduce unfavorable conditions for health equity.

In view of the above, in order to strengthen rural health practices and, consequently, improve the health level of these populations, the National Policy for Comprehensive Health of the Rural and Forest Populations (Política Nacional de Saúde Integral das Populações do Campo e da Floresta - PNSIPCF) was instituted in 2011, having as main objectives ensuring access to health services, reducing risks to diseases arising from the work environment and agricultural technological innovations and, above all, improving health indicators and quality of life. [6]

The field nurse relates daily to popular knowledge, beliefs and customs linked to the territory. There are popular practices that aim to remedy problems and aggravations or to promote health through alternative paths, diverging from the dictates of the hegemonic biomedical model. [7] Such practices originate from empirical knowledge, shared by generations, and therefore traditional, a construct of culture expressed in the daily lives of those who live and work in that space, the countryside.

Through the work of nurses in rural health, meanings, portraits and concepts are constructed that denominate and singularize the existence/experience of this population. Therefore, it is in the midst of the relationships established between the professional and the rural community that the representations are in fact created. [4]

These social representations are messa-

ges mediated by language, socially constructed, anchored in the context of the individual who emits them, providing specific knowledge to a given social group. Representations arise from the continuity between the external universe and the individual from individual/collective interrelations, and this is the result of the inherent power of human beings to create representative objects, events and attitudes. [8] Therefore, the following research question was outlined: what are the social representations of nurses about the health of the field?

Given the role of nurses in PC in specific populations in the field, and the permanent contact with subjects in their biopsychosocial aspects, this article aims to: analyze the social representations of nurses about the health of the field.

METHOD

This is an exploratory, qualitative study, anchored in the Theory of Social Representations (TSR). This theory can be considered a raw material for social analysis because it portrays reality, according to a certain segment of society. [9] In this sense, the object studied - rural health - is translated through the repertoire of the social group of nurses working in rural FHS.

The research was carried out with nurses working in Family Health Strategy in the rural territory of the municipality of Caruaru, located in Agreste Pernambucano, which has 69,18% of rural coverage considering the total of 18 units that were in operation. [10]

In this study, nurses participated with at least one year of experience in FHS, an important time to measure previous contact and experience with assistance. The exclusion criteria were vacation or leave. According to the established criteria, 11 nurses were interviewed.

An instrument composed of sociodemographic data (education, length of experience and gender) and open-ended questions was used. The technique of data collection was through semi-structured interviews, containing the following questions: 1) What comes to your mind when talking about the health of the rural population? 2) How do you perceive the health needs of rural families? 3) What is the role of the nurse who works in these rural units? Data collection took place between January and February 2018, the duration of each interview averaged 25 minutes, in a reserved place at the Municipal Health Department of the municipality.

It was found in the demographic characterization that ten of the participants were female and only one male. All of them with significant experience in Family Health Strategy, between five and 15 years of professional experience.

The interviewed nurses were identified by codes: E1, E2 ... For better data collection and reliability of the information, the interviews were recorded on audio and stored on a Pen drive, which facilitated the understanding at the time of transcription, making corrections of the language, deepening the investigation of the object that were transcribed and organized in a single textual corpus called 'field health'.

The data were analyzed using the textual analysis software Interface of R pourles Analyzes Multidimensionnelles de Textes et de Questionnaires (Iramuteq). It performs different types of analysis, from the simplest ones, such as the calculation of word frequency, to multivariate analyzes that include the descending hierarchical classification and similarity analysis. [11] This technique is used by researchers of social representations, as it allows the detection of co-occurrences between words, which facilitates the identification of the representation structure. [12] For this study, we opted to use the similarity tree (Figure 1) and the Word Cloud (Figure 2). The results were analyzed in the light of the current literature using the TSR.

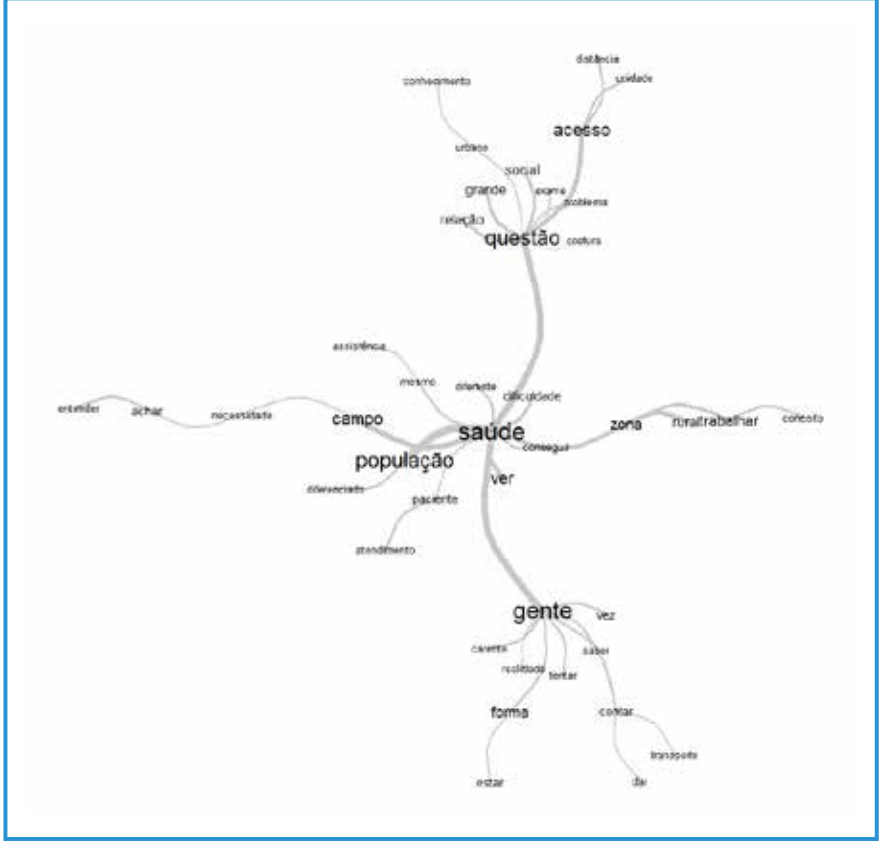
The study was submitted to the Human Research Ethics Committee - Hospital Complex HUOC/PROCAPE of the University of Pernambuco - UPE, with approval opinion on 10/02/2017 under No. 109.011 and CAAE 76749517.7.0000.5192. The participants had been informed and signed the Free and Informed Consent Term (ICF), according to the ethical and legal principles that govern the research with human beings of Resolution no. 510/2016 of the National Health Council. [13]

RESULTS

It was found in the demographic characterization that ten of the participants were female and only one male. All of them with significant experience in Family Health Strategy, between five and 15 years of professional experience, mainly in rural areas. For ethical reasons, in order not to identify the only male participant, we will accept the term 'nurse' for all participants.

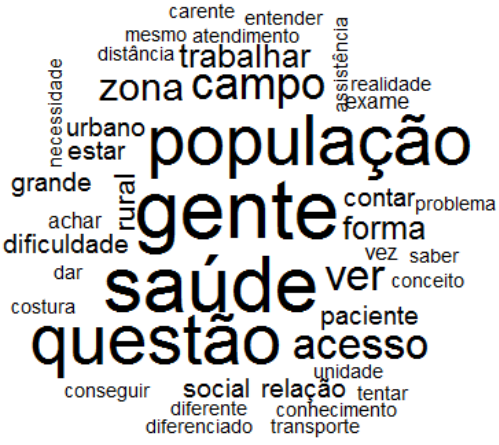
The textual corpus called 'field health' processed in the Iramuteq software that generated the figures, from a number of 30 text segments, 1028 occurrences and 168 active forms, with a frequency greater

Figure 1 – Similarity tree referring to the textual corpus 'health of the field'. Caruaru, Brazil, 2018.



Source: Research data, 2018.

Figure 2 – Word cloud referring to the textual corpus 'health of the field'. Caruaru, Brazil, 2018.



Source: Research data, 2018.

than three. Figure 1 represents the graph resulting from this processing called the similarity tree.

The Similitude Tree (Figure 1) is formed by three blocks or branches, with "health", "question" and "people" as evidence. The term "health" is centralized and contains the greatest amount of evocations and ramifications. In addition, there is a connection between the terms "access, field, population, work and form". As can be confirmed with the lines below:

> *"Okay, the main difficulty in the rural area is displacement [...] our post is too far away, we don't have a house nearby, my area is very extensive and the houses are far away." (E7)*
> *"That's what makes access to people in my unit difficult, it's transportation. Because the micro areas are very distant, they end up not having access." (E2)*
> *"The issue of detachment, due to the barrier of access, distance from home, difficulty in transport, all interfere in the health care of people in the countryside." (E4)*

Figure 2, evidenced by the Word Cloud, makes it possible to quickly visualize and identify evocations more frequently in the analyzed textual corpus. In this type of graphic representation, the words in larger size have the highest frequencies, when compared to the words of smaller size. Thus, the terms "population", "people", "health", "question", "field" and "access" stand out, which will be better understood with the following excerpts of speech:

> *"Access, which I think ... populations that have more difficulty accessing health". (E1)*
> *"The issue of access to health ... a lot to do with the issue of distance, the displacement of this population to the basic health unit." (E3)*
> *"The difficulty of accessing other*

levels of care, at the secondary level, at the tertiary level, due to the distance... I think this is the biggest difficulty." (E3)
"Issues of distance, questions of logistics, transportation, the referral of these patients themselves go to units that are located in an urban area." (E5)
"It is different from the city that is closest, it has transportation, it has everything, you can come and go. Not there [rural area], the bus only passes twice a day, it does not pass in all areas." (E7)

DISCUSSION

In the analysis of Figure 1, a representation objectified in the term "health" is revealed, however, there is a connection relationship with several structural elements such as: "access", "field", "population", "work" and "form" . The evocation of these terms by the participants points to a sense where the difficulties in working with various health problems are directly related to the population's access to the health unit.

It is observed, in the second branch, that there is a direct correlation of the terms "issue" and "access" to rural health. Both are linked to specific aspects of health, such as the services offered by the SUS network, public policies and programs. They are related to the identification of accessibility barriers, such as the distance from the FHU to the users' homes and the difficulty of commuting to reach these units.

The perception of the participants in this study resonates with a study carried out in a city in the state of Minas Gerais on access to health services, because, in the view of professionals and users, "access" is interconnected to the structural dimension that permeates the financing of the system of health and expose practical difficulties of health policies in the country such as geographic accessibility due to the distance from the user's residence to the unit. For the authors, this is a determining condition when evaluating rural populations. [14]

The implementation of the PNAB in 2006 was committed to the establishment of the family health strategy as a priority. Since then, the expansion of access and increasing coverage to the population through the FHS has been identified as fulfilling one of the dimensions of access. [15] This, which can be seen as the degree of adjustment between customers and the health system, conceptualized as the availability (volume and type) of services in relation to needs. [16]

For nurses working in Agreste Pernambucano, accessibility barriers are significant factors in the provision of care in the rural context, mainly because they understand that primary care is the main level of assistance present in this context and that their daily practice demands new modes of action.

Data from the National Household Sample Survey shows that the urban area has a greater offer of health services and better quality compared to the rural population, as well as access to health centers that is facilitated. [17] In view of this reality, users of urban centers seek treatment, rehabilitation, routine or preventive exams, while the rural population, mostly, when there is a concrete presence of diseases.

The reflexes of the difficulty of access of rural populations are indicated by the worst health indexes, social determinants and rates of preventive coverage, as well as the difficulty of access to the health system at all levels. The size of the teams and the distance (real and built by bureaucratic difficulties) create more obstacles in offering comprehensive health care. [4]

The conception of field health reported by nurses is influenced by the work developed in the professional field and by the subjective construction of the relationships established. Therefore, while creating the representation of an object, the subject is also constituted, as it is situated in the social and material universe. When expressing an opinion about an object, the contribution to the elaboration of a representation is assumed, its main characteristic is the production of behaviors and relationships with the environment. [8]

It is understood that these social representations in health are conceptions acquired throughout the nurses' professional experience and experience, as actors of the FHS action. In this way, some evocations present in the similitude tree as "form" in the sense of configuration and conformation and the term "try" in the sense of fostering and stimulating, reflect an attitudinal dimension where nurses assume for themselves social responsibilities that may have an impact on transformation of the local reality. Thus, rural health seems to demand from these practical actions that imply in improving access and health care.

The idea of committing oneself to the issues of access and accessibility difficulties was also brought up in the Word Cloud when presenting the term "people" as central. It is understood that it is a self-reference in formal language that consists of a way of referring to itself directly. However, the words "individual" and "population" that are co-occurring with "people" make up the semantic sense of "collectivity". Pointing out that health actions in the individual and collective scope, in primary care, which are present in the very constitution of nursing, as essence and specificity in the care for human beings [18] were incorporated by the participants of this study when developing activities in the field.

These aspects, in the rural context, are essential for the recognition that health is determined by the economic, social, cultural and environmental conditions in which rural communities and populations live. In addition, the land structure, basic sanitation, high rates of infant mortality, unhealthy conditions, illiteracy and other factors, determine the health conditions of the rural population and are evidenced in the Rural Health Policy. [6]

Through the social representations of

nurses, participants in this study, it is understood that the reality of rural health is distinct and has peculiar conditions that are based on history, culture and social relations. Implying professional demands centered on quality in the care provided, reception, well-being to users, and promotion of autonomy, through an accurate diagnosis of the real needs that the rural population demands.

The limitation of this study involves the participation of nurses who work in a single rural FHS micro-area. Still, the results allowed access to elements that can contribute to the work of nursing and Family Health teams in discussions and struggles for the reorganization of the care network in small cities. The scarcity of recent studies on the subject made it difficult to establish identities between the research findings and the reality of nurses in different contexts in the context of primary health care.

CONCLUSION

The population's difficulty in accessing health services assumes the centrality of nurses' social representations when recognizing the needs/restrictions of access of populations living in the countryside, whether facing geographic distances or other services in the network.

The study brings as innovations for teaching and research the existence of a Multiprofessional Residency in Family Health with an emphasis only on rural populations, which guarantees the maintenance of scientific productions about this work space and life. For nursing, theoretical and practical support for the creation of a care model based on the peculiarities of rural populations.

Therefore, it is necessary to value cultural aspects, historical differences between rural and urban, and to carry out studies that can enrich the process of permanent education of health professionals, providing a different conduct and performance in face of the reality found in these territories. ■

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