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ORIGINAL ARTICLE

PRACTICAL DIMENSION OF THE HEALTH PROFESSIONALS' SOCIAL REPRESENTATIONS ABOUT NEGLECTED DISEASES

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ABSTRACT

Objective: to analyze the practical dimension of health professionals' social representations about neglected diseases. Method: a qualitative study, supported by the Theory of Social Representations, developed between March and October 2018 in primary and secondary care units in the inland of Bahia, Brazil. The data were collected by means of in-depth interviews and submitted to lexical analysis using the IRAMUTEQ software. Results: the social representations consisted of a practical dimension that described the care process of health professionals with their difficulties and potentialities when facing neglected diseases. Conclusion: the practical dimension of the social representation indicated the need for public policies directed to neglected diseases, care practices in permanent education in health and professional training with comprehensive care.

DESCRIPTORS: Neglected Diseases; Public Health Nursing; Health Personnel; Health Manager; Poverty.

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INTRODUCTION

Neglected diseases correspond to a set of diseases caused by infectious parasitic agents that produce important physical, cognitive and socioeconomic damage in children and adolescents, especially in low-income communities. They are also understood as infectious diseases of major importance in public health and which ceased to receive proper attention by science as a whole[1].

Neglected diseases are endemic in 149 countries and affect more than one billion people worldwide. A large number of these diseases are caused by parasites and have at least one vector involved in their cycle. The populations of poor and developing countries become vulnerable to contracting such diseases, as they live with no adequate sanitation and in contact with vectors of diseases and animals that are parasite reservoirs[2].

In 2005, the Brazilian Ministry of Health launched a research and development program on neglected diseases that included six diseases: Dengue, Chagas Disease, Leishmaniasis, Leprosy, Malaria and Tuberculosis. In 2008, in the second edition of the edict, Schistosomiasis was added to the list of priority neglected diseases for the institution[3]. In the Health Brazil 2017 Report: An analysis of the health situation and of the challenges to achieving the Sustainable Development Goals, the Ministry of Health lists the following diseases as neglected: Chagas Disease, Schistosomiasis Mansoni, Leprosy, Lymphatic Filariasis, Tegumentary Leishmaniasis, Visceral Leishmaniasis, Onchocerciasis, Human Rabies, and Trachoma[4].

In 2015, a population study carried out by the Ministry of Health in 5,570 endemic municipalities identified 104,476 new cases of neglected diseases, with higher detection rates in the North and Northeast regions; 7,786 deaths due to multiple infections were recorded mainly in the Midwest, Southeast and Northeast regions[3].

A study carried out on this topic pointed out that, in the health professionals' social thinking, the interface between neglected diseases and the social, individual and political conditions stands out, in line with the idea of neglect by the institutions involved in combating these diseases. In this way, it is perceived that, in fact, few sectors of society realize the magnitude of these diseases, and that no effective measure to fight against such problems are provided[5].

It is understood that the panorama presented at the global and national levels strengthens the need to expand studies on neglected diseases, having as a starting point the analysis of the health professionals' knowledge about these diseases, in order to understand the social thinking of this group, involved in coping with these diseases, from the perspective of the Theory of Social Representations (TSR).

The knowledge elaborated by the health professionals undoubtedly favors understanding of the attitudes and practices to cope with neglected diseases. Social representations are practical thinking modalities directed towards communication, understanding and the domain of the social, material and ideal environment[3]. From the context presented, the objective is to analyze the practical dimension of health professionals' social representations about neglected diseases.

METHOD

This is a qualitative research study grounded on the Theory of Social Representations in its procedural approach. It was conducted in primary and secondary level health institutions from the municipality of Jequié-BA, between January 2018 and April 2019.

The group of participants consisted of 27 health professionals who worked in direct care of people affected by at least one of the diseases considered as neglected by the Ministry of Health. The criteria for inclusion in the group of participants were as follows: being a nurse, physician or nursing technician at the institution, totaling nine participants for each of these professions; and being a health professional with at least one year of experience in institutions that develop actions in the treatment of neglected diseases. The exclusion criteria were as follows: being a health professional not working in the assistance provided to people affected by neglected diseases and professionals who were distanced from the institutions.

The data were collected by applying a thematic script for the in-depth interviews, from March to October 2018. The participants were recruited in the primary and secondary level health units, and they were asked if they wished to participate. Approach to the participants included the guidelines about the research objective and an explanation regarding the data collection method. After the approach, dates and times were scheduled to apply the script according to the participants' availability. Application of the collection instrument lasted approximately 30 minutes.

In-depth interviews represent an important method for social representation studies, being characterized as a concluded interaction situation. It is believed that interviews enable access to the content of a representation and to the attitudes developed by the individuals[6].

The interviews were recorded with the aid of an electronic device, applied only by one of the authors of this study and literally transcribed for submission to the Lexical Mechanized Content Analysis technique with the aid of the IRAMUTEQ (Interface de R pour les Analyzes Multidimensionalnelles de Textes et de Questionnaires) software. This program enables different types of textual data analysis, from very simple ones, such as basic lexicography (calculation of word frequency), to multivariate analyses (descending hierarchical classification, similarity analyses)[7].

This processing resulted in a corpus that included all transcribed interview texts on neglected diseases, exclusively presenting the health professionals' psychosocial thinking on this topic. For this study, the results from the Descending Hierarchical Classification (DHC) analysis were considered, which allowed analyzing the lexical roots and offered the contexts in which the classes are inserted, according to the text segment of the research corpus[8].

The participants' testimonies were coded based on the order number of the UCE, the "health professional" term and the value of the association of the chi-square test with a given class. Example: *(E 05, Physician, x^2=419.90)*.

The study was approved by the Research Ethics Committee of the State University of Southern Bahia, under favorable opinion No. 2,113,727/2017.

RESULTS

The health professionals were divided into three categories: nine nurses, nine nursing technicians and nine physicians; in their majority, 23 (85.1%) were female, aged between 26 and 69 years old, most of them belonging the age group from 37 to 58 years old. It was noticed that 14 (51.8%) professionals have a training time from 11 to 30 years, showing that this social group encompasses a series of facilitating conditions for the organization of the work process along with coping strategies for neglected diseases. A percentage of 11 (41%) was also seen, corresponding to 10 years of training, and this period strengthens the active and qualified participation of this group in the formation of the social representation.

The general corpus consisted in 27 texts, separated into 1,076 text segments (TSs), with leverage of 1,043TSs (96.93%). A total of 38,421 occurrences (words, forms or terms) emerged, of which 2,349 were distinct words and 978 had a single occurrence. The text segments were sized and classified according to the DHC, which defined seven classes divided into two axes, as shown in Figure 1.

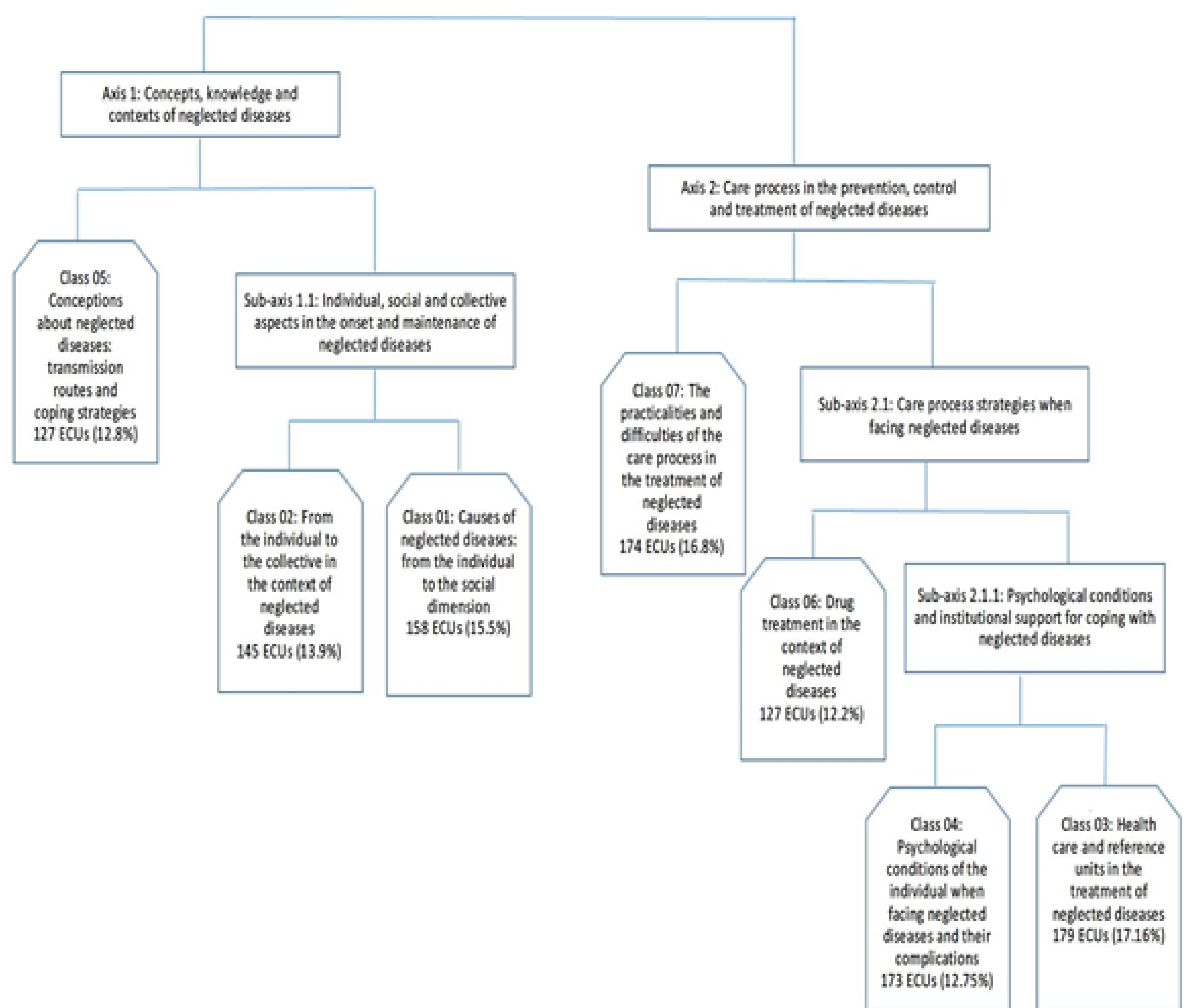

Figure 1 - Distribution of the thematic classes into axes, derived from the Descending Hierarchical Classification. Jequié, BA, Brazil, 2018
Source: The authors (2018)

The approach of this study focuses on the discussion of Axis 2, called "Care process in the prevention, control and treatment of neglected diseases", which, at first, includes Class 07, 'the practicalities and difficulties of the care process in the treatment of neglected diseases' and sub-axis 2.1, 'care process strategies for neglected diseases'. This sub-axis encompasses Class 06, 'drug treatment in the context of neglected diseases', and sub-axis 2.1.1, 'psychological conditions and institutional support for coping with neglected diseases', which, finally, offers contexts to classes 04, 'psychological conditions of the individual facing neglected diseases and their complications', and 03, 'health care and reference units in the treatment of neglected diseases'.

Axis 02 enabled the elaboration of the practical dimension of the health professionals' social representations about neglected diseases, as it mainly dealt with the care process in the prevention, control and treatment of these morbid entities, with reflections on the attitudes of those involved in the triad of care (individual, health team and manager). The convictions and beliefs of these professionals about the various care and self-care postures and practices in the face of neglected diseases emerged.

Class 07 presented welcoming; team-patient relationship; active search; and immunization as practicalities of the assistance process regarding neglected diseases. In this logical structure of care, the care process begins through reception by the team, consolidating the convictions and forms of knowledge in the treatment of the diseases under discussion.

In the health professionals' discourse there are several highlights to the reception performed by the health team and its implications for the treatment of diseases diagnosed during health care for these individuals.

The team here welcomes you very well, I have nothing to say no, the professionals are responsible for identifying the disease and ensuring the patient's treatment, I do the consultations here, carry out the diagnosis of the diseases and establish the drug treatment. (E 05, Physician, x^2=449.85)

Performing the diagnostic exams too, and the practicality is direct access to the team, which welcomes very well all those who arrive here. (E 06, Physician, x^2=373.30)

Other practicalities pointed out by the health professionals in the control and treatment of the diseases were listed, such as performing the active search and immunization.

Here I develop the consultation with physical examination, active search, control of contacts, indication of prophylactic treatment, immunization in some cases and even education in health together with community health workers. (E 09, Nurse, x^2=378.24)

In Class 07, the health professionals also evidenced the difficulties faced, both by users and by health workers, in the treatment of neglected diseases, in particular the lack of resources to carry out the services.

The main difficulty is this, when some resources are lacking in the unit and the person's problem is not solved, and the facilitating factor is the empathy of the team, the welcoming we have, it really works here, the patient only leaves here without solving their problem when there's no other way. (E 20, Nurse, x^2=431.01)

Difficulties to follow treatment, delay in diagnosis, lack of resources on another occasion, the patient had to pay for sputum smear microscopy. (E 23, Nursing technician, x^2=262.45)

With regard to the lack of resources, there is evident absence of medication and shortage of tests to diagnose the disease, compromising effectiveness of the treatment; as well as the patient's own social resources, such as diet and difficult access to the health unit. All these difficulties imply the perpetuation of diseases and reduce the resoluteness of health institutions and of the professionals' work process.

The health professionals' thinking, in Class 06, verified the importance of drug treatment, even without technological innovations, which would possibly contribute better conditions of adherence to the use of medications.

The main treatment is medication because it's closer to our work, there are other activities, but we have more autonomy with this, the team welcomes the patients in an appropriate way, treating each one with their own peculiarities. (E 07, Physician, x^2=324.41)

The treatments are the use of antibiotics and also the treatment of hepatitis, according to the type and condition of the patient, the difficulties are performance of tests and delayed

delivery of results, leaving patients there transmitting the disease due to absence of a precise diagnosis. (E 10, Physician, x^2=315.60)

In Class 04, the health professionals expressed in their psychosocial thinking the idea that the psychological aspects influence coping with the diseases, going beyond the biomedical view of health and implementing other models that explain the health-disease process; in this case, the psychological dimension evidenced in the participants' reports is highlighted.

I have sometimes observed, let's survey this epidemiological profile because we've noticed people with really psychological problems and that, in fact, I still see this situation very loose. (E 15, Nurse, x^2=223.11)

Another feeling that emerges as a constituent of the individual's psychological situation, according to the thoughts of these professionals, was fear: fear of the complications arising from the disease, and fear related to the lack of information about the treatment and possible cure for these problems; finally, verification of the diagnosis of these morbidities by the individual awakens this feeling of fragility in the face of the health status.

Fear of the disease, fear of not being cured, fear that the neighbor has had it and that they have not been well until today, we'll explain why the neighbor wasn't well because they didn't follow the correct treatment. (E 11, Nurse, x^2=168.77)

With the medication at the right time, with the psychological apparatus, we know that it has a lot of impact, and these nuances that will make him realize that he's being seen in the unified health system. (E 15, Nurse, x^2=171.29)

In Class 03, there was the opportunity to evidence the main places of care for the treatment of neglected diseases, observing the individual's itinerary in the referral and counter-referral system, as well as to identify the risk practices adopted by the individuals in the face of the disease process and the feelings presented during this moment.

For him to take the medication there, they often come back because they didn't have the necessary welcoming in these units and then they come back here, so it's a problem and then I do the diagnosis and treatment here. (E 01, Physician, x^2=231.91)

DISCUSSION

Welcoming is an action that must exist in all care relationships, in the bond between health workers and users, in the practice of receiving and listening to people, and it must be established as a tool that enables care humanization, expands the population's access to the health services, ensures problem resolution, coordinates the services and links the establishment of relationships between professionals and users.

In this sense, it can be asserted that the practice of welcoming is present in all care relationships and can be configured in different ways, depending on who participates in the processes and how and under which conditions this process takes place. Given the above, instead of asking whether, in any service, the welcoming tool is used or not, perhaps it is more pertinent to assess how it is materialized or employed. Welcoming is less conveyed in the discourse about it than in the practices themselves[9-10].

In turn, in the continuity of the care process of neglected diseases, the relationship between the team and the patient is strengthened as there is a determination of a care plan for the restoration of health by highlighting dialog as a care instrument, which allows the health professional to list the real needs of the individual and, based on this, establish treatment strategies.

The relationship between patient and health professional is the basis of any and all treatments, and its quality exerts a direct impact on health. The quality of this communication, accompanied by a good therapeutic bond and the professional's sensitivity in perceiving the context as a whole, is a driving force for providing efficient and comprehensive health care to the patient. However improved a technique may be, it will tend to be innocuous or alienating if it is not associated with a good professional-patient relationship[11].

In Class 06, the health professionals constituted in their representation the relevance of drug treatment in the care process, placing it as one of the main coping strategies for neglected diseases. This thought reflects the reproduction, by health professionals, of the exclusively biomedical model for the health care of the population, to the detriment of alternative care models that expand the reductionist vision and the curative model, focusing on strengthening measures aimed at inserting the individual at the center of care, observing the completeness and multi-cause factors of illness.

Specific access to pharmaceutical care, in addition to being addressed in complementary legislations, is ensured by two state policies: the National Medications Policy and the National Pharmaceutical Care Policy. In order to make access to medications viable, the prerogative of the Unified Health System (*Sistema Único de Saúde*, SUS) to formulate and implement economic and social policies is even clearer, since this is an area deeply influenced by commercial practices and different market interests, often conflicting with the public interest[12].

This would be an ideal path for the innovation of technologies aimed at the development of drugs that are closely linked to the treatment of poverty diseases, with the application of existing pharmaceutical care policies and also with the participation of managers, especially in regions with greater endemicity of these diseases, compacting the local reality by including in their municipal health plans the priority of this innovation in medications.

Emotional aspects can precede the triggering of physical problems, as well as diseases caused by organic agents can also trigger different emotional reactions. Health can be influenced by several conditions, such as: individual differences, personality traits, beliefs and attitudes systems, behaviors, social support networks and the environment. Although the experimental evidence is still inconsistent, in some cases, data from studies on health and behavior suggest that the psychological processes and emotional states are directly related to the etiology and spread of diseases[13].

The psychological assessment in medical environments can be considered an adequate tool in the appropriation of decisions regarding the differential diagnosis, type of treatment needed and prognosis. Early detection of behavioral problems and/or psychological/psychiatric disorders in patients inserted in medical environments can mean a great difference regarding the type and quality of care provided to the patient, as well as a reduction in suffering and institutional operating costs. The psychological assessment should not only be linked to hospitalized patients, but also to different spaces and specialties in health, such as specialty private clinics or health centers[14].

It was noticed that the health care provided by the professionals participating in this study takes place both in primary care and in reference institutions (secondary care); therefore, the organization of the health services has different characteristics according to the degree of care complexity. However, what needs to be observed in this context is compliance of this organization with the determinations provided for in the scope of the SUS. Currently, there is the idea of building care in health care networks, where the needs, regardless of their complexity, are met in health services organized in care networks.

Integrated systems or health care networks have produced significant results in several countries and are considered effective both in terms of internal organization (resource allocation and clinical coordination, among others), and in their ability to face the most recent challenges of the socioeconomic, demographic, epidemiological and

sanitary scenario, such as the proportional growth of chronic diseases, the rise in the costs of technologies, and the special needs resulting from population aging[15].

The health professionals' psychosocial thinking about neglected diseases produced a practical dimension that was constituted by social practices, represented by the attitudes of the triad (individual/health professionals/managers), showing the description of the activities inherent to each one, many times being supported by the neglect and others by the manifestations of strategies to fight against the diseases herein studied.

This social group delimited by the health professionals develops practices that favor the perpetuation of neglected diseases, as they do not understand the relevance of social conditions such as poverty and ignorance in the promotion of these diseases and by associating the incidence and prevalence of these diseases to the exclusively biological dimension. There was a social configuration pointing to neglect with neglected diseases of the participants in this health-disease process, each one with their responsibilities, issuing a strictly biomedical and incipient conception in the control of these diseases.

The social reality produced by the health professionals showed the relevance of social practices in order to build an image about neglected diseases, mainly with regard to their causes, as for the social group these diseases still occur in the region not only because of the biological dimension, but also for other reasons that involve the conditioning and determinant factors of the health-disease process.

In this context, the notion of negligence needs to be assumed, not only in terms of diseases, but mainly of neglected people, which requires critical questioning of the rationales that inform the ways of operating the policies since, on the one hand, they present undeniable advances in terms of public health but, on the other, they maintain the rules and outlines within the frameworks of subordination and dependence[16].

A social reality, as understood by the TSR, is created only when the new or unfamiliar is incorporated into consensual universes. The fact that this occurs under the weight of tradition, memory, the past, does not mean that new elements are not being created and added to the consensual reality, producing changes in the social thinking system, or continuing the construction of the world of ideas and images in which people live[17].

The social reality, based on the health professionals' thinking, means a new idea and image about the social practices that lead to neglected diseases, supported by the neglect and ignorance of the subjects that make up the triad of individual, health professional and politicians. It is these practices that have become familiar to the context of neglected diseases, considering that their endemicity and perpetuation continue to devastate large part of the world population, reducing quality of life, cognitive development and comprehensive health.

As study limitations, the difficulty interviewing more professionals or other categories that also develop actions to prevent and fight against neglected diseases is highlighted, which may not reflect the full dimension of the professional practices carried out within the municipality.

CONCLUSION

The practical dimension of the health professionals' social representations about neglected diseases consisted of the description of the practicalities and difficulties encountered by the professionals when facing these diseases. Coping strategies were presented, such as the discussion about drug treatment, the influence of the psychological aspects in the disease process, with fear, stigma and prejudice as pillars in the individual

reconstruction of the health-disease process and, finally, access to units that are a reference in the fight against neglected diseases.

Considering that the health professionals' social representations manage and influence their care practices, changing the reality that surrounds them and leading new and essential knowledge for the control, prevention and treatment of neglected diseases, the study raises reflections on the practices of the subjects involved in the health-disease process (individual, health team and manager). This is because the impact that social construction has on the professional practice cannot be ignored, considering the structural conditions of the services offered, the training for the production of care, and the public policies aimed at people with neglected diseases.

Therefore, it is urgent to develop public policies directed to the context of these morbidities, in addition to redefining the health professionals' care practices with actions of permanent health education and instrumentalization in the field of professional training in health, from the perspective of comprehensive care.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Santos CS, Gomes AMT; Drafting the work or revising it critically for important intellectual content - Santos CS, Gomes AMT, Souza FS, Pinheiro GML, Rodrigues VP, Machado JC, Nogueira VPF; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Santos CS, Gomes AMT. All authors approved the final version of the text.

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