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Objective. To analyze the social representation structure of health professionals about care delivery to people living with HIV/AIDS and to reflect on that structure in the light of the National Humanization Policy. **Methods.** Exploratory study based on the Social Representations Theory, with emphasis on the structural focus. In total, 114 health professionals from Belém, Pará/Brazil participated in the development of the study, working at four services specialized in HIV/AIDS care, between August 2011 and April 2013. The data were collected through free evocations of the inducing term "Taking care of HIV/AIDS patient" and analyzed using the software *Ensemble de Programmes Permettant L'analyse des Évocations-EVOC2003*. **Results.** The group of subjects has a positive representation structure, organized around the categories: sensitive care, technical care and educative care. When reflecting on the representations structure, four out of five principles of the National Humanization Policy are observed (principle 1 - valuation of the subjective and social dimensions, principle 2 – stimulus for the production of health and subjects, principle 3 – teamwork and principle 5 – construction of autonomy and empowerment). **Conclusion.** The social representation structure of the health professionals about care for people living with HIV/AIDS signals the affective, conceptual and informative dimensions, converging with most principles of the Brazilian humanization policy.

Key words: HIV; acquired immunodeficiency syndrome; humanization of assistance.

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Estructura de representación de profesionales de la salud sobre el cuidado de las personas que viven con VIH/SIDA

Objetivo. Analizar la estructura de la representación social de los profesionales de la salud sobre el cuidado de las personas que viven con el VIH/SIDA y reflexionar sobre dicha estructura a la luz de la Política Nacional de Humanización. **Métodos.** Estudio exploratorio que tuvo el apoyo de la Teoría de las Representaciones Sociales, con énfasis en el enfoque estructural. Fue desarrollado con la participación de 114 profesionales de la salud de Belém, Pará/Brasil en cuatro unidades de atención especializada en VIH/SIDA, desde agosto de 2011 hasta abril de 2013. Los datos se recolectaron a partir de evocaciones libres del término inductor" Cuidando a la persona con VIH/SIDA " y se analizaron con el software *Ensemble de Programmes Permettant L'analyse des Évocations-EVOC2003*. **Resultados.** El grupo de profesionales tiene una estructura de representación positiva, organizada en torno a las categorías de: cuidado sensible, cuidado técnico y cuidado educativo. Al reflexionar sobre la estructura de las representaciones se observan cuatro de los cinco principios de la Política Nacional de Humanización (principio 1-valorización de la dimensión subjetiva y social, principio 2- estímulo a la producción de salud y de sujetos, principio 3- trabajo en equipo y, principio 5- construcción de autonomía y protagonismo). **Conclusión.** La estructura de la representación social de los profesionales de la salud sobre el cuidado de las personas que viven con VIH/SIDA señala las dimensiones afectiva, conceptual e informativa, siendo convergente con la mayoría de los principios de la política humanización del país.

Palabras clave: VIH; síndrome de inmunodeficiencia adquirida; humanización de la atención.

Estrutura representacional de profissionais de saúde sobre cuidar de pessoas que vivem com HIV/Aids

Objetivo. Analisar a estrutura da representação social de profissionais de saúde sobre cuidar de pessoas vivendo com HIV/aids e refletir sobre tal estrutura à luz da Política Nacional de Humanização. **Métodos**. Estudo exploratório que teve suporte na Teoria das Representações Sociais, com ênfase na abordagem estrutural. Foi desenvolvido com a participação de 114 profissionais de saúde de Belém-Pará/Brasil, em quatro unidades de atendimento especializado em HIV/aids, no período de agosto de 2011 a abril de 2013. Os dados foram coletados por meio de evocações livres ao termo indutor "Cuidar da pessoa com HIV/aids" e analisados pelo software Ensemble de Programmes Permettant *L'*analyse des Évocations-EVOC2003. **Resultados**. O conjunto de sujeitos apresenta uma estrutura representacional positiva, organizada em torno das categorias cuidar sensível, cuidar técnico e cuidar educativo. Refletindo sobre a estrutura das representações observam-se quatro dos cinco princípios da Política Nacional de Humanização (principio 1- valorização da dimensão subjetiva e social, principio 2- estímulo a produção de saúde e de sujeitos, principio 3- trabalho em equipe e, principio 5-construção de autonomia e protagonismo). **Conclusão.** A estrutura da representação social dos profissionais de saúde sobre o cuidado de pessoas que vivem com HIV/aids aponta dimensões afetiva, conceitual e informacional, bem como é convergente com a maioria dos princípios da política de humanização do país

Palavras chave: HIV; síndrome de imunodeficiência adquirida; humanização da assistência.

Introduction

The original representation of the Acquired Immunodeficiency Syndrome – Aids in the 1980's appeared as a counterpoint to the dominant sexual morality in different parts around the world. Thus, the syndrome was elaborated and represented as an epidemic of immorality and also as a consequence of the loss of moral and social standardized, which influenced the care delivered to these people around the world and in Brazil.[1] As from the 1990's, the transformations in the social meaning of aids were gradually revealed, and new contributions started to influence care as well.

People living with the Human Immunodeficiency Virus – HIV/Aids start to take a stand and also demand transformations in the professionals' actions, with a view to humanized care.

From this perspective, it is highlighted that, in Brazil, in the 1990's, guided by the human and social sciences, health practice and teaching provided the bases for the establishment of a care humanization policy at the start of the next decade.[2] In subsequent decades, some health professions started to consider it as the focus of their care. In nursing, this movement consolidated further in the 1990's. This conception acknowledges

humans as social beings who constantly relate with others and their midst, transforming them and being transformed by them, that is, they play a prominent role in the health actions.[2] This contribution is in line with the transformations in the actual social meaning of aids.

It is known, however, that people living with HIV are still greatly discriminated against, which can interfere in the care delivery, as the moral values of the professionals involved in their care are strongly present during care delivery.[3] The social representations guide these professionals' practices, as well as the way they take care of people living with HIV/aids. These people should be known in order to devise training actions to potentiate the professionals' humanized action/ activities, including nursing professionals. Nursing is integrated in the team and care is integrated among all. The nursing professionals' qualification at the referral services needs to be enhanced in order to potentiate humanized educative care actions. Nursing cannot stay at the margin of this reflection process about the care for people living with HIV/aids from the perspective of humanization. Proposed in 2003, the National Humanization Policy of Care and Management of the Unified Health System (PNH) states that humanizing is "offering high-quality care, articulating the technological advances with welcoming, improving the care environments and the professionals' work conditions".[4]

Social representation studies specifically developed by nursing aim to understand and give meaning to the care practices, the characteristics of the profession and the aspects of the health-disease process. This reveals the relations established between the subjects and the phenomenon, patients and multiprofessional teams, evidencing who the professional is, what he knows, the type of care offered and the construction of the meaning of this care.[5] The objective in this study was to analyze the structure of health professionals' social representation about care for people living with HIV/aids and to reflect on this structure in the light of the National Humanization Policy.

Methods

An exploratory study was undertaken, using Social Representations Theory (SRT) from the structural perspective for theoretical support. Serge Moscovici formulated the SRT at the end of the 1950's, which received visibility based on the publication of his study La Psychanalyse: Son image et son public in 1961, marking the establishment of an innovative perception on the integration between the individual and social perceptive phenomena.[6] For Moscovici, the concept-phenomenon differs from other forms of (intellectual or sensory) knowledge because it establishes a specific relation between the subject and object of knowledge. This subject represents himself by representing the object, imprinting his identity in what he represents.[7] The structural approach was proposed by Jean Claude Abric in 1976, who affirmed that any social representation is organized around a social core, determining its meaning and internal organization, as a subset of the representation, composed of one or more elements that, if they did not exist, would disorganize the representation or grant it a completely different meaning.[8]

The study was developed in Belém-Pará/Brazil, at four care services specialized in HIV/aids: Clinic for Infectious Diseases at Hospital Universitário João de Barros Barreto, Center for Testing and Counseling, Referral Unit in Special Infectious-Parasitic Diseases and the Health Care Center in Acquired Infectious Diseases. The participants were 114 health professionals, who work at the referral services and deliver care to people living with HIV/aids. They were contacted at their places of work. All health professionals contacted accepted to participate in the study. No relation had been established with the participants before the study. The sampling followed the method established in the multicenter project, which defined a convenience sample, and considered a sample of 100 professionals per city as a minimum requirement for the development of this study.

Concerning the professionals' profile, it is highlighted that 100 (87.7%) were female. As

for age, 34 (29.8%) professionals were up to 35 years of age, 39 (34.2%) professionals were between 36 and 45 years and 41 (36%) were 46 years or older. What the length of experience in the program for Sexually Transmitted Diseases (STD) and Aids is concerned, 69 (60.5%) have worked in the program less than five years and 45 (39.5%) more than five years. As regards the time since graduation, 36 (31.6%) have graduated up to five years earlier, 60 (52.6%) between 6 and 15 years and 18 (15.8%) 16 years or more. With respect to the professional category, 24 (21%) were nursing technicians, 13 (11.4%) social workers, 13 (11.4%) nurses, 13 physicians (11.4%), 7 (6.1%) psychologists, 7 (6.1%) pharmacists, 2 (1.8%) auxiliary nurses, 1 (0.8%) dentist and 34 (30%) dental technicians, occupational therapists, speech therapists, physiotherapists and not specified.

The data were collected between August 2011 and April 2013, using a form that contained the Free Association (FA) technique. The form was applied by a group of collaborators/interviewers affiliated with the multicenter project. These collaborators were prepared and trained to apply the form. It was applied according to the participating health professionals' availability, at the place and time previously agreed upon. The data were collected during the morning and afternoon shifts, at the workplaces and at other locations suggested by the professionals. Each interview took between 40 and 60 minutes, at a private place, where only a collaborator/interviewer and the participating health professional were presented. First, the informed consent form was read, the research objective was explained and two copies of the form were signed to register the subjects' agreement.

The Free Association technique consisted in asking the subjects to produce five words or expressions that immediately came to their mind when they thought of the inducing term "Taking care of people with HIV/Aids", representing the production of answers in a situation of normal expression, when the subject talks on his behalf. To produce the corpus, the order in which the words were produced was used in order to guarantee the spontaneity of the evocations, supposing that the most important words are cited first. This data collection technique permits evidencing the semantic universe associated with the term-object studied, as well as its image dimension, faster and more dynamic than other methods with the same objective.[8]

The data were processed and coded by a collaborator of the multicenter project at the laboratory of the Universidade do Estado do Rio de Janeiro under the leadership of the general and national coordinator of the project. The evocations were subject to quantitative analysis, based on frequencies and means, while the content of the terms and words evoked was subject to qualitative analysis. For the quantitative analysis of the data, the software *Ensemble de Programmes Permettant L'analyse des* Évocations (EVOC) 2003 was used. EVOC2003 calculated and informed the simple frequency of each word evoked, the weighted average occurrence of each word in function of the order of evocation and the mean weighted average orders of the set of terms evoked. Based on the result of the processing, a block of four places was obtained, which corresponds to four quadrants with four sets of terms. The software does not identify social representations and social representations cannot be calculated; when the evoked words are processed, the software simply presents a probable central and peripheral structure of the social representations, based on the block of four places, from the perspective of the structure approach of the social representations.

For the qualitative analysis, the terms in the block of four places was subject to semantic and content analysis and the terms were grouped in categories associated with the object of study, according to the semantic universe the subjects employed. The research complied with National Health Council Resolution 466/12, which sets guidelines and regulatory standards for the ethical aspects of research involving human beings. The multicenter project this subproject is affiliated with was assessed and approved by the Ethics Committee of the Universidade do Estado do

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Rio de Janeiro, Protocol 048.3.2010, and the Ethics Committee at Universidade do Estado do Pará, Protocol 0069.0.321.000-10. All subjects signed the Informed Consent Form.

Results

In total, the 114 health professionals evoked 557 words, associated with the inducing term "taking care of people with HIV/aids", of which 139 were different. Table 1 presents the distribution of the terms evoked in the Block of Four Places; this was obtained using a cut-off point with a minimum frequency 14, mean frequency 20 and Mean Order of Evocations (MOE) 3.0 (in a variation from 1 to 5). Twelve words or terms evoked are distributed across the four quadrants.

Table 1. Representational structure of the object "taking care of people with HIV/aids". Belém, 2015

Mean Frequency	MOE < 3			MOE ≥ 3		
	Evoked Term	Frequency	MOE	Evoked Term	Frequency	MOE
≥20	Love	34	2.618	Attention	21	3.048
	Care	28	2.714	Training-professional	20	3.100
	Education-health	25	2.800			
≥14 and ≤19	Welcoming	14	1.286	Support	15	3.000
	Self-protection-professional Information	16	2.625	Humanized care	17	3.176
	Solidarity	19	2.895	Respect		
		17	2.353		14	3.214

In the probable central core (upper left quadrant), there are the terms love, care and education-health. The elements of the central core include the elements that probably represent central cognitions for the social representations, as they are the most frequent and are considered hierarchically more important among the evocations.[9] In this study, these terms or words are expressed at a frequency of 20 or higher and, at the same time, obtained evocation means lower than 3, that is, they are evoked more readily. The term that stands out is *love*, with an evocation frequency of 34 and an MOE of 2.618. It originates in Latin and has multiple meanings in Portuguese: "element that grants meaning to existence and humanizes the relations to the extent that it opens existential space for the other with himself".[10] Another central term is *care*, a word with biased meanings, referring to care as assistance to people living with HIV/aids as well as professional protection in view of exposure to HIV infection at work. Its frequency was 28 and the MOE 2.714. The term *education-health* also present in the central core is associated with the professionals' educative activities in the context of HIV/aids, with can be related to the users as well as the health workers. Its frequency corresponds to 25 and the MOE 2.800.–

The first periphery (upper right quadrant) contains the terms attention and professional training. The most relevant peripheral elements possess the highest evocation frequency and are the least important according to the interviewees.[11] These terms or words in this study are expressed with a frequency of 20 or higher, with evocation means higher than 3. In the second periphery (lower right quadrant), the terms support, humanized care and respect are displayed. These elements are more closely related with the reality experienced, possibly recent elements of the representation, associated with the more immediate context, which join the most specific characteristics of the representation in the practical context.

The peripheral system promotes the interface between the reality and the central system and is more sensitive to the conditions of the context,

permitting the integration of the experiences and histories. It serves as a bumper between a reality that questions it and a central core that is not expected to change easily. The disagreements from reality are absorbed by the peripheral schemes, which thus guarantee the (relative) stability of the representation.[11] The contrast zone (lower left quadrant) contains the terms welcoming, self-protection-professional, information and solidarity. This quadrant consists of the contrasting elements, elements with a low frequency but high priority. The contrast zone contains elements that characterize variations in the representation in function of subgroups, but do not modify the central elements and the representation itself, indicating changes or transition of a social representation.[11] The group of subjects presents a positive representational structure, organized around the categories: sensitive care (with the terms love, attention, support, solidarity and respect); technical care (with the terms care, welcoming, professional self-protection and humanized care); educative care (with the terms health education, professional training and information).

In the category sensitive care, "taking care of people with HIV/aids" is linked to an affective dimension. Care is an action that takes place between people. Therefore, it cannot be separated from emotions like love and cannot be neutral in relation to human values, it should be a bilateral process between the health professional and the being who receives care.[3] When we reflect on the category sensitive care in the light of the National Humanization Policy – PNH, one of the guiding principles is revealed, the first of five, which emphasizes and values the subjective and social dimension in care.[4] In the category technical care, "taking care of people with HIV/aids" is linked to a conceptual dimension, in which these professionals already posses further knowledge and are able to take distance from the stigmas and prejudices and focus on more holistic care. When we reflect on the category in the light of the PNH, two other guiding principles are revealed: the second, which stimulated commitment to the production of health and the production of subjects; the third, which aims to strengthen

multiprofessional team work.[4] In the category educative care, "taking care of people with HIV/aids" is linked to an information dimension, in which the information can potentiate/empower both the professional and the person living with HIV/aids. When we reflect on the category in the light of the PNH, yet another guiding principle is revealed, the fifth principle of the PNH, which emphasizes the use of the information, communication and continuing education.[4]

Discussion

The presence of the terms love, attention, solidarity, support and respect (category sensitive care) in the social representation structure of the health professionals remits us to discussions on the presence of an affective dimension in the field of the social representations.[12] The representation is structured knowledge that plays a determinant role in how the individuals see and react to the reality and, possessing affective loadings, it is crossed by an affective component. The subjectivity highlighted in the first principle of the PNH is defined as the human being's capacity to be unique.[13] The care takes place at the encounter of subjectivities, establishing an open dialogue between health professional and health service user, in which feelings, actions and reactions complement one another. The valuation of the subjectivity should not merely focus on the health service user, considering that the humanization of care depends on the consideration that the professional's subjective dimension is a vital component of the care process.[14]

In disease situations in which the health service user is more weakened, the health professionals need to adopt a higher degree of sensitivity, which will facilitate a better understanding of the users' subjective needs, guaranteeing more comprehensive care.[14] In our perspective, an affective dimension in the relation between health professional and user is important, considering the humanization process as a dialogue that permits and stimulates the integration between technical care and the user's life projects.[15] The presence of the terms care, welcoming, professional self-

protection and humanized care (category technical care) in the social representation structure of the health professionals appoints a conceptual dimension. The social representations are guides for action. They function as a form to interpret the reality, which dictates the individual's relations with their social and physical context, determining their behaviors and practices, guiding the actions and social relations.[8] It can be affirmed that the health professionals in the study present care that is more rooted in technical-scientific knowledge, which can represent this care beyond the disease and its stigmas.

Professional self-protection figures as an important element of HIV/aids care. When aids was discovered, the health professionals' exposure to blood started to be emphasized.[16] It should be highlighted that nursing professionals are the most frequent accident victims, mainly auxiliary nurses and nursing technicians, as they are constantly assisting the patient, handling needles, venous catheters and administering medication.[17] The welcoming of people living with HIV/aids should be based on listening, so as to favor treatment compliance. The health professionals needs to serve as a source of information and incentive on the continuity of life and needs to construct an affective-cognitive structure between the professional and user.

The second principle of the PNH underlines the importance of commitment to the production of health and the production of the subject. The managers, health professionals and users of the health service are focused on, as the main responsible for changing the health care models and for the management of the work process, prioritizing the citizens' needs.[18] The health service users should not be excluded from their therapeutic process. They should all be inserted in the action of health care. The third principle of the PNH evidences the need to strengthen multiprofessional teamwork. The execution of care by different health professionals favors the quality of this care, as a single professional category is not capable of taking care of all health service users during the health-disease process.[14]

The presence of the expression health education, professional training and information (category educative care) in the structure of the health professionals' social representation points towards an information dimension. Health education is a strategic contribution in the health practices focused on HIV/aids, turning into a fundamental tool in view of the increase in the number of HIV/aids cases and the changes in the epidemiological profile.[19] The development of educative actions that involve not only the people living with HIV/aids but the population in general is a form of health prevention and promotion, which should not only focus on vertical information transmission, but serve as a possibility to transform the individual into a critical subject concerning the health problems. In this health education context, the role of the health team is evidenced, which occupy a strategic position to combine information that emerges from the interaction between the different professionals and the population. Training courses for health professionals should be redirected to permit gaining educative competency, so that the professionals can perform health education in view of the relation with the reality the user experiences.

The fifth principle of the PNH evidences information, communication and continuing education. The health professionals in the HIV/aids context considered health education as a task of orientation and information, associated with a form of care, guided by clinical-therapeutic contents and the responsibility of the entire team. This act of guiding and informing is linked to precaution-prevention (self and hetero-protection), involving the people living with HIV/aids and the people who take care of them. The health professionals also consider education at work important, as even more experienced professionals still face doubts.[20]

This study concluded that the social representation structure appoints affective, conceptual and informational dimensions, it is "positive", and is organized around the categories sensitive care, technical care and educative care, indicating a new posture towards this care. The reflection in the light of the National Humanization Policy

thus permitted the conclusion that the structure of the social representation converges with most of the principles of the humanization policy. Thus, predominantly developed according to those principles, the care actions are strengthened. We identified four out of five principles, indicating that humanized care is in course, that advances are made in the care forms, intertwining the professionals and the users' subjectivity, the valuation of their prominent role, the awareness of the need for continuing education processes with a view to increasingly qualifying this care, and the importance of care based on updated scientific knowledge by the entire multiprofessional team.

The results indicated the absence of one of the principles, which refers to the activity in networks with a high level of connectivity, in a cooperative and solidary manner, in compliance with the guidelines of the Unified Health System (SUS). Thus, it is highlighted that the humanization policy is a possible and inexhaustible ideal, but also an ongoing process of construction and reconstruction from the perspective of health work and care. A judicious delimitation of the Humanization concept is fundamental for its guiding principles to be truly applied, assessing which of the possible forms of executing this humanization are in accordance with the reality of the health services. The multiplicity of humanization concepts strengthens the need to discuss and reflect on its delimitation, so that the proposal is truly implemented in daily care practice.

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