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DOUBLE WORK SHIFT: IMPLICATIONS ON NURSES' HEALTH DUPLA JORNADA DE TRABALHO: IMPLICAÇÕES NA SAÚDE DA ENFERMEIRA DOBLE JORNADA DE TRABAJO: IMPLICACIONES EN LA SALUD DE LA ENFERMERA

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ABSTRACT

Objective: to analyze the double shifts and health impacts of female nurses working in the Family Health Strategy. **Method:** descriptive qualitative study, carried out with 13 nurses through semi-structured interview. Data were analyzed according to the thematic analysis technique. **Results:** four categories emerged: 1. Conceptualizing health: nurses' perception about care of themselves; 2. Health practices and their relationship with public and domestic work: impacts on physical and mental health; 3. Being woman, mother and nurse: contextualization from gender perspective; and 4. Concern / negative perception of body self-image front to gender stereotypes. **Conclusion:** the study may contribute to reflection in face of the gender issues that are implicit in the daily lives of women / nurses; it is important to understand them as determinants of the health-disease process. **Descriptors:** Gender Relations; Primary Health Care; Work Shift; Women's Health; Health Professional.

RESUMO

Objetivo: analisar a dupla jornada de trabalho e as repercussões na saúde da enfermeira atuante na Estratégia Saúde da Família. **Método:** estudo descritivo, de abordagem qualitativa, realizada com 13 enfermeiras, por meio de entrevista semiestruturada. Os dados foram analisados de acordo com a técnica de análise temática. **Resultados:** emergiram as categorias: 1. Conceito de saúde: percepção das enfermeiras acerca do cuidado de si; 2. Práticas de saúde e sua correlação com o trabalho público e doméstico: impactos na saúde física e mental; 3. Ser mulher, mãe e profissional de Enfermagem: contextualização sob a ótica de gênero; e 4. Preocupação/percepção negativa da autoimagem corporal diante dos estereótipos de gênero. **Conclusão:** o estudo poderá contribuir para a reflexão perante as questões de gênero que se apresentam implícitas no cotidiano das mulheres/enfermeiras, sendo importante compreendê-las como determinantes do processo saúde-doença. **Descritores:** Relações de Gênero; Atenção Primária à Saúde; Jornada de Trabalho; Saúde da mulher; Profissional da Saúde.

RESUMEN

Objetivo: analizar la doble jornada de trabajo y las repercusiones en la salud de la enfermera actuante en la Estrategia Salud de la Familia. **Método:** estudio descriptivo, de enfoque cualitativo, realizado con 13 enfermeras, por medio de entrevista semi-estructurada. Los datos fueron analizados de acuerdo con la técnica de análisis temático. **Resultados:** surgieron las categorías: 1. Concepto de salud: percepción de las enfermeras acerca del cuidado de sí; 2. Prácticas de salud y su correlación con el trabajo público y doméstico: impactos en la salud física y mental; 3. Ser mujer, madre y profesional de Enfermería: contextualización sobre la óptica de género; y 4. Preocupación/percepción negativa de la autoimagen corporal frente a los estereotipos de género. **Conclusión:** el estudio podrá contribuir para la reflexión sobre los problemas de género que se presentan implícitas en el cotidiano de las mujeres/enfermeras, siendo importante comprenderlas como determinantes del proceso salud-enfermedad. **Descriptores:** Relaciones de Género; Atención Primaria de Salud; Las Horas de Trabajo; Salud de la Mujer; Profesional de la Salud.

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INTRODUCTION

Gender, class, generation and ethnicity relations suffer variations according to the historical context, marked by the gradual assimilation of the guidelines from the hegemonic social classes. For women, considering Foucault's view of power, in which nothing is imposed, there is a development and acceptance, in a tacit way, of submission behaviors to men as socially validated truths by science, culture, religion and tradition.¹ Thus, women's social roles have long been restricted to domestic chores and raising children, while men were responsible for protecting the home and support it financially.²

These differences in the behavior of men and women are based on social and historical buildings that use physical and biological differences to explain and justify relationships, identities and gender roles.^{3,4} Expressed socially, they create power hierarchies ranging from marital relations at home to institutional asymmetries in the labor market that interfere with the exercise of professions. By dictating which aspects are feminine and which are masculine, they create privileges and limitations that have been designed and socially accepted.^{3,5,6}

So, men and women take different and unequal roles that are defined, fixed and socially transmitted, by virtue of naturalization of cultural acceptance of the place of women and men in society, thus legitimating a hierarchical power relationship between genders.^{3,6}

With the rise of the feminist movement, women began to reflect on their social roles, including their space in the labor market and gender equality, starting to question the ideologies that used to simplify them and, considering that some of these ideologies remain, still simplify them, often characterizing them as mere objects.²

Although the Brazilian Federal Constitution of 1988 affirms that there is equality in rights and obligations between men and women, there are still inequalities related to gender, reaffirming the culturally constructed differences and determining for women activities considered typically feminine, such as the care of home and children and in the labor market, where targeted and adapted tasks are assigned to them.⁷

Thus, with the inclusion of women in the labor market, there has been a strong presence in professions still focused on the "skills" attributed to the female image, such as the care. As an example, the Nursing profession continues to be performed predominantly by women. According to data from the Brazilian Federal Nursing Council (COFEN), females are the majority (87.24%) of the nursing workforce in Brazil.⁸

Nursing carries intrinsic characteristics that have been assigned exclusively to women and rooted in the social imaginary, as this profession is often seen as an extension of the home and the roles of women as caregivers.⁶ In this perspective, it is a profession that requires emotional and physical balance. However, the nurse has difficulty in managing the vulnerability that user/family presents, either in the hospital environment, or in the Family Health Strategy (FHS), mainly due to double and/or multiple working hours, low wages and inadequate working conditions or excess of personal responsibilities and multiple roles played in primary health care, where care functions combine with the bureaucratic functions and the constant vigilance that require greater attention and commitment and, consequently, produce overload and stress.⁸

In this context, the nurse's work process in the FHS is a social phenomenon that has conflicts and dichotomies between practice and theory, between doing and knowing, increasing the responsibilities of the professional front to the population they serve, making them vulnerable to neglect the aspects related to their physical and mental well-being due to overload of roles in both the public environment and the household.⁹

Based on the above, this study aims to analyze the double shifts and health impacts of female nurses working in the Family Health Strategy.

METHOD

This is a descriptive qualitative study carried out with 13 nurses of the FHSs in the city of Juazeiro do Norte/CE, located in the Cariri microregion, in the southern state of Ceara/CE during the period from April to May 2014.

Data production occurred in the FHSs that compose the 2nd and 5th health districts. The primary care of the said

municipality is divided into six health districts, in which there are 66 FHSs. Data collection took place in the 2nd and 5th health districts, selected by beholding greater quantity of FHSs allocated in the urban area of the municipality. It was adopted as inclusion criteria: female nurses working in the selected FHSs of the health districts in the urban area should have been working for at least one year in the FHS.

The technique used for data collection was a semi-structured interview aimed at obtaining information spontaneously, without being conditioned to previously established standards, in which a script with open questions that allowed the interviewees talk on the theme was used.

After obtaining participants' consent, individual interviews were recorded in informants' workplaces and then transcribed for analysis according to the prerogatives of thematic analysis, used to reveal the units of meaning present in interviews and to build the categories.¹⁰

Thus the following categories emerged: (1) Conceptualizing health: nurses' perception about care of themselves; (2) Health practices and their relationship with public and domestic work: impacts on physical and mental health; (3) Being woman, mother and nurse: contextualization from gender perspective; and (4) Concern / negative perception of body self-image front to gender stereotypes.

So, after analyzing the interviews and performing the categorization, authors conducted the interpretation of the results, by citing excerpts of responses identified by the abbreviation of the word nurse (N.) followed by a number representing the order of the interviews. Subsequently, there was discussion in association with the relevant literature.

It is noteworthy that the development of the study took place under agreement of the Municipal Health Department. The voluntary participation, security and the well-being of recruited participants were guarded by signing the Informed Consent Form (ICF), respecting their autonomy, dignity and anonymity.

This article is a part of a research entitled "Modernization of the labor market and its influence on the health of nursing professionals: an analysis from a gender perspective", approved by the Research

Ethics Committee of Faculty of Juazeiro do Norte (FJN/CE/BRAZIL) under Opinion No. 626,600 (CAAE 19367213.7.0000.5624), thus obeying the principles of Resolution No. 466/12 of the National Health Council.

RESULTS AND DISCUSSION

♦ Sociodemographic and professional profile of the participants

The age of participants ranged from 24 to 39 years old, with a mean of 29.46 years. Most of them were married, had children, lived in Juazeiro do Norte and in surrounding municipalities as Barbalha and Crato, with monthly income ranging in 2014 from three to eight minimum wages, of which the average was 5.3 wages.

These findings corroborate the quantitative and percentage distribution of nursing professionals related by age group in Brazil, which shows that the workforce of this category is mostly made up of young people aged between 26 to 45 years, corresponding to 63.23%.⁸ In contrast, nursing in Brazil has no starting salary nor workday regulated by the national laws; both are set in free negotiation or collective agreements, monitored by the labor unions.⁸

Regarding training, eight nurses had specialization. As for the employment relationship, eight had temporary contracts and the others were permanent public employees by the city government. The four nurses who reported having more than one type of employment relationship justified it by the need to supplement their income and maintain socioeconomic status. With regard to the length of professional experience, eight participants had been working as nurses for less than five years and the others, between five and 10 years in their respective FHS. It is also noteworthy that although five nurses have reported being single, all said they performed some domestic activity.

These findings show that there is a permanent stimulus for the expansion of primary care, with the increase of jobs for nurses in the public sector, as the Family Health Strategy.⁸ However, the Unified Health System (SUS) also has the challenge to promote, implement and incorporate education in an integrated, continuous and permanent manner in the work, training and qualification processes of these health professionals.

These narratives enabled inferring health perceptions, quality of life and self-image of the interviewed nurses, which will be discussed in thematic categories.

♦ **Category 1 - Conceptualizing health: nurses' perception about care of themselves**

Nurses' perception in relation to their own health evidenced the influence of their knowledge of the definition of health by the World Health Organization (WHO). When asked about what health is, they replied according to the WHO definition, which defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease.¹¹

It means social, mental and physical well-being [...] It includes leisure, education, family income, whether the person has a job, has money. Whether the person has access to health services [...] a comprehensive well-being [...] in a way that it can satisfy the person [...] the way I take care of my health is not okay, because there is that thing, we guide other people and sometimes forget to put into practice in our lives. (N11)

Health is the balance between the various components of the human being, the physical, psychological and even the spiritual well-being. It is the balance between body and mind, including the psychological, physiological and spiritual aspects. (N04)

The definition presented by them relates to the academic knowledge and professional experiences, making it clear the influence that this concept has in relation to their point of view and the lifestyles they consider healthy. However, even though they claim health as fundamental, participants revealed contradictions between what they think health is and the relationship with the care of themselves, as their reports show negligence and/or deficiencies of care in face of their own health.

To take care of the other, one must also take care of oneself. On the other side, to take care of oneself, one need to know who they are, which means to examine oneself interiorly.¹²⁻³

Self-knowledge is an essential element for understanding and adopting a healthy lifestyle. Thus, "only when the body is in a healthy condition, it may be possible to take care of the other satisfactorily"^{13:10}. This means that taking care of oneself is inseparable from taking care of others. This emphasizes the need to understand the limits of one's own body and adhere to the

care necessary for a psychological, physical and spiritual balance.

♦ **Category 2 - Health practices and their relationship with public and domestic work: impacts on physical and mental health**

Health practices and adoption of self-care behaviors are directly related to work assignments as a FHS nurse and the activities carried out at home, as wife and/or mother.

In the sociocultural imaginary, work is only related to those activities that bring financial profit, so the household chores and responsibilities with family, as they not to generate money, are not considered as work. However, work is not restricted to professional activities.

In this context of economic devaluation of domestic activities, as they do not generate goods and do not produce income, they are considered unproductive labor, a theory based on capitalist ideals.¹⁴ This devaluation comes from a misogynist thinking resulting from a sociocultural construction of gender inequalities settled in patriarchal ideologies, that attributes a condition of inferiority to women, as the domestic activities are performed mostly by them, in a sexist movement that tends to disqualify the feminine qualities to make them unqualified and despicable.

In professional framework of FHS, overload and depreciation contribute to psychological illness as well as to the emergence of common mental disorders (CMD) that appear in the form of insomnia, fatigue, irritability, forgetfulness and difficulty of concentrating, which in the long term can cause physical and psychological sequelae.¹⁵ Nevertheless, nurses tend to develop a sense of responsibility, emotional involvement and social commitment in the conduction of their professional activities.⁸

Lack of time and the burden of domestic and professional duties are the most common factors that generate negligence with health and impede the adoption of preventive behaviors and health promotion, especially the sedentary lifestyle, poor diet, insufficient sleep/rest pattern, not performing tests, with negative consequences for health and wellness.

I do not do physical activity because I do not have time, because I have children [...] and when I get home there is nobody who can take care of them for me to take a walk, which along with my health habits, which are bad, because we have no options of healthy food at work. (N06)

I sleep late, wake up early to take care of myself, I help children to get dressed to go to school, then go to work and then when I am home I take care of my baby [...] and during the day I have no rest at all, then it all ends up affecting my health. (N02)

[...] my body feels when I am overloaded, with too much stress; I have migraine attacks that make it impossible for me to do anything. (Enf. 09)

[...] not even Pap smear, I do not do it, there has been five years since I did it, I have no time, I am very overloaded. It is complicated because of the excessive working hours, I work 40 hours [...] and it requires a lot of us, we end up worrying too much about others and forgetting about us, our health [...] we work hard, strive and have nothing in return. (N01)

[...] we end up accumulating functions, I am not married [...]. I am a housewife too! ... When I get home [...] I have to do accumulated assignments of a housewife. (N07)

Overloading of functions assigned to the nurse generates stress and psychosomatic symptoms that impact the body in the form of headaches and fatigue, making impossible for them to exercise their activities and enjoy a better quality of life.

In this sense, stress is a response to the pressures imposed on body and mind. One study showed effects of physical and mental burden of Nursing work, which was ranked as the fourth most stressful profession because of the responsibility for the lives of people and the proximity to users, in which suffering is almost inevitable, requiring greater commitment in psychological functions.^{16,17}

Meeting basic needs associated with specific aspects of the human condition as identity, equality, freedom and self-fulfillment contribute to achieving quality of life and health for nurses.¹⁸ This means to say that quality of life is the result of balance between professional and personal life, especially when work provides conditions, time and encouragement for leisure, physical activity, family, rest, and also training and continuing education. Thus, the narratives presented by the nurses reveal that there is lack of time to meet vital basic needs to recharge energy and

rest. Deficits in healthy habits and physical activity were commonly reported problems.

Another problem that involves the non-adoption of physical activity is dissatisfaction with the income that leads them to seek other employment, which ends up exceeding the limits of body/mind, resulting in having no control of healthy eating and reduced time for leisure and rest.

Results indicate that the external conditions lead to increased exposure of diseases and risk factors for psychological and physical illness. Gender inequalities are still evident in the family, where there is a double shift in domestic chores and in the care to the children, which are assigned only to women, who feel obliged to execute them.

These obligations assigned to a particular gender come from unequal relationships in the identity constitution of masculinity and femininity, which, today, are based on perceived differences between the sexes. It has not always been this way, since long before the discussions about gender women were already occupying unequal and lower spaces even in the perspective of gender equality.¹⁹

Thus, the sexual division of labor, produced in gender relations, imposes unlimited journey, which, associated with household chores, produces overload and can contribute to the progressive deterioration of women's health.²⁰

It is important to point out that duties related to domestic chores are not restricted to married women, but to women in general due to their construction in the social and cultural imagination, as the single nurses also reported performing household activities, with the accumulation of functions, assuming also the role of "housewives".

♦ Category 3 - Being woman, mother and nurse: contextualization from gender perspective

Currently, the multiplicity of roles tends to be a contemporary woman feature, although since the beginning the woman's ability to perform several tasks simultaneously is highlighted, with a tendency to providing care, which is seen as an exclusive characteristic of women.²¹

The analysis of the nurses' speeches allowed identifying grievances, conflicts and tensions due to their desire, by their need

and/or socially determined obligation, to perform tasks simultaneously, making it clear that despite their achievements in the labor market, they have not stopped to perform obligations at home, with children and husband, thus prevailing the labor division determined by gender inequalities.

[...] we have no available time to exercise those roles properly. So, we only perform half of each, or sometimes never complete them or ultimately choose to complete one or two, that is, cease to do something and do the other thing. (N03)

[...] I am a mother, I have several things to do, if I had no children I might handle work, take care of my health. There is little time and too much to do. (N05)

Everything is interconnected, right? You never cease to be a single person, I leave home to work but I cannot stop being me to be only nurse, of course you will exercise your carrier. And there is the condition as a woman also, because even though women have had many achievements, they never cease to be a being with weaknesses, vulnerabilities. So there are certain things that always bring stress, concern, anxiety, even if you have no children, but there is always a parent, nephews [...] there are always a few things that we carry for us, that we not share with anyone, it is that thing that we absorb more than other family members. (N12)

Because the woman, besides everything, is a mother. The child falls ill, who will take care? The mother! Who has to take to the doctor? The mother! Who spends sleepless nights and has to give medication? The mother! We need to be there going strong, it is our duty as a mother, right? But at times we get weak because of concerns, we need help because gradually we start being unable to accomplish all alone. (N08)

Women adopt from the sociocultural patterns some concepts and responsibilities related to household activities, and often take assignments for themselves. Thus, both the domestic and the public female universe is impregnated by gender issues as society dictates that they should take care of the house, the children and the husband.

By establishing roles to be played by women, there as a crystallization process as a result, i.e., as they are subject to these roles, they end up incorporating them, which indirectly defines and restricts women in their ways of being, acting and expressing themselves socially. This incorporation of roles is held in the form of beliefs and values that reinforce gender inequalities, since it is based on social differentiation.²²

Thus, when women assimilate and incorporate these "social values" in their personal training, they become hostage to their own conceptions and roles, and when they often require the male presence and/or help, they unconsciously become unable to give up on these roles and responsibilities within the family. By not sharing with men the responsibilities with the children, especially the "invisible" work of concerning and care planning, they reproduce the current model of traditional gender roles.²⁰

Thus, it appears that as a result of gender inequalities, maternity and paternity do not enjoy the same responsibilities. On the other hand, by taking on new roles, women bring with them their own responsibilities as females, such as motherhood, responsibility to the children and the home, as well as the need to be within the beauty standards.

This becomes crucial when interfering with their daily work, and they have to prioritize their tasks, which can generate crises and doubts about their feminine identity. As the female identity is a socio-historical construction that is in constant transformation, it becomes a complex, dynamic and conflicting concept that does not always understand the multiple roles of women, as they have changed in time within a social, history and cultural context.²³

The acquisition of new/multiple roles and behaviors by the modern woman has not broken with the logic of gender asymmetry. On the other hand, due to the pressures and gender stereotypes, women sometimes feel unable to hide the fragility and vulnerability, historically considered feminine features, and they sometimes feel strong and determined as to their status and their roles.

It is noticed that despite the accomplishments and achievements for autonomy, freedom and financial independence, the social gender behaviors remain, and it is important to realize that personal achievements claimed by a woman still have to be inserted between motherhood, career and relationship. Balancing these wishes is a major challenge that women have to face in front of society and themselves.²¹

The multiplicity of roles and demands on women's lives significantly interfere in their daily lives, as, by prioritizing one over the

other, they forget to take care of themselves, including the aspects related to health.⁷

The reports show that the available time for women to take care of themselves is related to the duration of the working hours, the number of children, the stage in which children are and the help means found to perform housekeeping and offspring care.

Reports also evidence the persistence of gender inequalities in the division of household duties, burdening women not only with the responsibility to adapt to the social space but also to take care for children/husband, and to organize and maintain the household activities.

Such situations reflect directly on professional recognition, requiring from nurses greater improvement, dedication and "demands" in the performed activities, which often generates a saturation and limitation, mainly due to lack of time. As a consequence, negligence in the care of health is evident, since people who play multiple roles are more likely to have signs and symptoms of health problems and this interferes with the adoption of healthy lifestyle habits.¹⁵

♦ Category 4 - Concern / negative perception of body self-image front to gender stereotypes

Modern beauty standards generate the building of a self-acceptable image, giving priority to overvaluation of image, and to looking good, which is intrinsically linked with the concept of self, being influenced by interactions between the being and the environment where they live.²⁴

The woman, seen as a sex symbol and male's desire object, must comply with the current "beauty standard". Thus, the female image, to please men, must aesthetically incorporate some attributes to be beautiful, thin, seductive and good-looking. Also, if possible, women should behave passively in relation to men, taking a subordinate position, so as to reassert male dominance and the woman as object of men's actions and desires, as well as the chauvinist ideology of having and showing the woman as an award/achievement.^{25,26}

On the other hand, taking care of body image makes up a basic social health need of modern women, which should be achieved through exercise, diet, healthy habits and aesthetic treatments.

[...] so when I acquire health, it contributes to my self-esteem and thus influence in good relationships, in my quality of life, in accepting my image [...] I have changed my whole diet and people perceive, make comments. (N13)

Physically I have some problems that worsen a little my state, my image, but I am always softening it, seeking aesthetic treatments. Surgical treatment, not yet! I prefer for now to seek better food habits since I want to lose weight [...] and therefore I would be more beautiful for my husband. So this is a goal that would make very satisfied. (N11)

[...] I have no time for anything, if I want to do a manicure, fix my hair, I have to do it at night, when I can. Sometimes I do it myself at dawn not to get ugly, clumsy; otherwise, what will others think of me? (N10)

The influence of beauty standards, the search for a socially acceptable image, which is also a gender issue in women's lives, even though it is linked to health and wellness, proved to be a recurring concern among the interviewees. In this sense, body and female sexuality models persist and may be perceived in facing situations in their social life.²⁷

The negative perception of self-image is characterized as a prerequisite, linked to gender issues, in which women need to follow social stereotypes to meet men's needs of having a good-looking woman at their side, following beauty standards in force, thus reaffirming the male view of women as the object of their actions and desires, as well as of power relations. On the other hand, caring for self-image shows confidence and trust in oneself and is crucial for women to obtain prestige, social status, femininity and attraction power.^{28,29}

The body image disclosed by the media follows the "beauty standards" and symbolizes personal and professional success. The woman who does not adhere to this standard becomes stigmatized and lowered, and may have feelings of dissatisfaction, guilt, frustration, anxiety and aesthetic devaluation of the body.²⁹

CONCLUSION

The double work shift and the overload of assignments influence nurses' health, especially by not allowing them to have time to care for themselves. These consequences arise from relations and gender inequalities that permeate their personal, professional and social life.

It was found that gender issues and their impact are present in public and domestic spaces, generating overload of functions and contributing to neglect of self-care, therefore increasing the vulnerability to health diseases and interfering with the adoption of preventive and health promotion behaviors.

There is need for self-reflection and awareness of nurses to reorganize their time and tasks in order to include the care needed to adopt and maintain healthy lifestyles. In this sense, women need to feel autonomous to overcome these patriarchal models that sustain gender asymmetries.

There is need to consider gender issues as determinants of the health-disease process and to formulate public policies aimed at workers' health, able to contemplate and minimize the potential damaging factors to health, and the redefinition of male and female roles.

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