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ORIGINAL ARTICLE

THE HUMANIZATION IN THE BASIC HEALTH CARE SERVICES: CONCEPTIONS OF HEALTH PROFESSIONALS

A HUMANIZAÇÃO NOS SERVIÇOS DA ATENÇÃO BÁSICA DE SAÚDE: CONCEPÇÕES DE PROFISSIONAIS DE SAÚDE

LA HUMANIZACIÓN DE LOS SERVICIOS DE ATENCIÓN PRIMARIA DE LA SALUD: CONCEPCIONES DE PROFESIONALES DE LA SALUD

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ABSTRACT

Objective: to analyze the conception of higher-level professionals who assume the management of the Family Health Units about the humanization as a criterion for (re) organization of the service and of improvement of the care provided to the user. **Methodology:** it is a qualitative study, with professionals who assume the management of the units in which the Humanization Policy was implemented, in a Bahia municipality, in 2010. The data were collected through eight interviews and, for making the analysis, we have used the content analysis technique. The research project was approved by the Ethics Research Committee, according to the Opinion nº 038/2010. **Results:** there is plurality of understandings about the humanization, which might be characterized as a positive aspect if it is used to unify the ideas for the collective building of interventions within the local health coverage. However, the viewpoints presented by each respondent are still reduced due to the breadth of the concept of humanization. **Conclusion:** the findings have revealed the importance of making use of the assumptions of the Humanization Policy to guide practices and reorganize the service in the pursuit for a quality care. **Descriptors:** Humanization, Health Services; Management.

RESUMO

Objetivo: analisar a concepção dos profissionais de nível superior que assumem a gerência das Unidades de Saúde da Família acerca da humanização como critério de (re) organização do serviço e de melhoria da assistência prestada ao usuário. **Metodologia:** estudo qualitativo, com profissionais que assumem a gerência das unidades em que foi implantada a Política de Humanização, em um município baiano, no ano de 2010. Os dados foram coletados por intermédio de oito entrevistas e, para a análise, utilizou-se a técnica de análise de conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética, segundo o Parecer nº 038/2010. **Resultados:** há pluralidade de entendimentos sobre a humanização, fato que pode ser caracterizado como aspecto positivo se utilizado no sentido de congregar ideias para a construção coletiva de intervenções no âmbito da saúde local. Contudo, as visões apresentadas por cada profissional ainda são reduzidas devido à amplitude do conceito da humanização. **Conclusão:** os achados revelaram a importância de se utilizar os pressupostos da Política de Humanização para nortear práticas e reorganizar o serviço na busca por uma assistência de qualidade. **Descritores:** Humanização; Serviços de Saúde; Gerenciamento.

RESUMEN

Objetivo: analizar la concepción de los profesionales de nivel superior que asumen la gerencia de las Unidades de Salud de la Familia acerca de la humanización como criterio de (re)organización del servicio y de mejoría de la asistencia prestada al usuario. **Metodología:** estudio cualitativo, con profesionales que asumen la gerencia de las unidades en que fue implantada la Política de Humanización, en un municipio bahiano, en el año de 2010. Los datos fueron recogidos por intermedio de ocho entrevistas y, para el análisis, se utilizó la técnica de análisis de contenido. El proyecto de investigación fue aprobado por el Comité de Ética, según parecer nº 038/2010. **Resultados:** hay pluralidad de entendimientos sobre la humanización, hecho que puede ser caracterizado como aspecto positivo si utilizado en el sentido de congregar ideas para la construcción colectiva de intervenciones en el ámbito de la salud local. Con todo, la visión presentada por cada profesional todavía es reducida, debido a la amplitud del concepto de la humanización. **Conclusión:** los hallados revelaron la importancia de utilizarse los presupuestos de la Política de Humanización para nortear prácticas y reorganizar el servicio en la búsqueda por una asistencia de calidad. **Descriptor:** Humanización; Servicios de Salud; Gerenciamiento.

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INTRODUCTION

The SUS is a single and social project whose principles of universality, integrality and equity are grounded in the Brazilian Federal Constitution of 1988. The Health Organic Law nº 8080/90 asserts that the State has the duty to assure the health in practices of planning and implementation of economic, social, and, consequently, health policies aimed at reducing risks of diseases and other health problems, as well as the establishing conditions that assure universal and egalitarian access to actions and services for its promotion, protection and recovery.¹

For ensuring the access the health service, the public health system is organized into levels of health care, being that one of them is the Basic Health Care (known as ABS). The Brazilian Ministry of Health, through the Ordinance nº 2488, of October 21st, 2011, characterizes the Basic Care as “a set of health actions, both individually and collectively, which covers the health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, damage reduction and health maintenance with the purpose of developing an integral care. Moreover, “it adds that the ABS should be “the preferential contact of users”, and should be guided by “the principles of universality, accessibility, bonding, continuity of care, integrality of care, accountability, *humanization*, equity and social participation”.^{2:3}

By highlighting the principle of humanization, this is operationalized with the rescue of the basic fundamentals that guide the health practices in the SUS, thereby recognizing managers, executive managers, workers and users as active subjects and protagonists of health actions; the building of different spaces for meetings among the subjects, as well as the knowledge exchange; the networking with multiprofessional teams, with transdisciplinary action; the care for demands of different subjects and the pact between the different levels of management of the SUS and the different levels of achievement of the public health policies.^{3:19-20}

In Brazil, the National Humanization Policy for Health Care and Management (known as PNH), established in 2003, understands humanization as a public health policy that should go through the different actions and managerial levels of the health services. The PNH is as challenging task towards the production of new attitudes by workers, managers and users, as well as in relation to the production of new forms of ethics in the

fields of work, management and health practices, thus overcoming problems and challenges of the daily life.⁴

Accordingly, our worrying involving the issue “Humanization” has emerged, mainly with regard to the concepts of health professionals on this topic. Hence, we have defined as study objective: to analyze the conception of higher-level professionals who assume the management of the Family Health Units about the humanization as a criterion for (re) organization of the service and of improvement of the care provided to the user.

THEORETICAL BENCHMARK

The term “humanization” is not considered, according to the literature, as a new term, given that is used since the Renaissance Period, between the late Middle Ages and the mid-Modern Age. Nonetheless, in health the scope, this entry has added other meanings and uses, and it has become the issue of the building of a Health Policy, besides an intense topic of discussions on Bioethics. Hence, this might be discussed from different viewpoints in order to promote a reflection to guide the practices and increase its potential to change the reality in the health scope.

The expression “humanization” leads us back to the Renaissance philosophical foundations of the humanism, by allowing disrupting the illusion of novelty in its use, as well as exploring its transformations and metamorphoses, by applying the discussions on health in this scenario. “The metamorphoses drive us to an exercise of overcoming, not towards the topics, but of the logic that seeks precursors and functional reasons. We do not assume the position of historical continuity, but the thematic (re)updating that both keeps something as makes changes”.^{5:328}

In contemporary civilization, the objective and subjective conditions for obtaining a high degree of humanity for all members of the human species are already given by the high degree of productive power. For these guidelines, humanizing is simply to target such capabilities with sights to extend and distribute, integrally and equally to the humanity, a set of benefits and results considered sine qua non properties of the human condition.⁶

Humanizing is also guaranteeing to the word its ethical dignity. Accordingly, the human suffering and the perceptions of pain or pleasure in the body, for being humanized, need that both the words and the subject who expresses them are recognized by the other, as well as this subject needs to hear words of

recognition from the other.^{6:280} For the Brazilian Ministry of Health, humanizing is “offering quality care articulating the technological advances with the welcoming, by bringing improvement in the care environments and in the working conditions of professionals”.^{7:6}

Deslandes⁸, when citing the definition of humanizing contained in official documents of the Ministry of Health, states that the suffering, the pain and the pleasure expressed by the subjects in form of words need to be recognized by the other, given that the things of the world only become humanized when they pass through the dialogue with the fellow people.

The Humanization Policy proposed by the Ministry of Health uses the term “humanization” in a positive perspective that would result in valuation and warranty of autonomy of the protagonists in the process of health production: users, workers and managers, with a consequent increase in the degree of co-responsibility in the health and subjects production. This policy presents has as guideline the building of more horizontal relationships between professionals and users, by emphasizing that the subjects/users receive the warranty of their rights.^{5:332}

Thus, the PNH should be realized not as a vertical programming, but as a cross-sectional proposal with the concern of proposing changes with positive impacts, by articulating all subjects involved in the process of health production: managers, workers and users.⁵ The policy brings a relevant focus with regard to the increasingly emerging need for expanding and, especially, improving the ability of organizations to satisfactorily meet the individual and group demands regarding the health. In this sense, the humanization should:

Consider the valuation of different subjects involved in the process of health production - users, managers and workers; fostering the autonomy and the protagonism of these subjects; increase of the degree of co-responsibility in the health production; establishing the solidarity bonds and the collective participation in the management process; identifying the social needs of the health field; changing models of care and management of work processes, by focusing on the needs of citizens and the health production^{6:278}

METHOD

This qualitative study was conducted in a municipality located in the South Reconcave Region of Bahia State along the BR 101⁹, included in the Macro-East Region of the State¹⁰, and that hosts one of the campuses of the Federal University of the Bahia Reconcave

(known as UFRB). Regarding the health system, the municipality has more than 20 Family Health Units (known as USFs), besides having basic health units, supportive units, oral health teams and reference services.

The used research field has covered five units of that municipality in which the Humanization Policy was implemented, as a pilot project. The nurses and dentists who work in these units and perform managerial activities thereof in the period of the aforementioned policy implementation were invited to participate in this study. The units will not be cited with sights to ensure the privacy and confidentiality of the involved subjects. Thus, eight (08) individuals agreed to participate in this study, who provided the information for the conducted analysis.

We have collected data from primary sources, through the semi-structured interview technique. The interview took place in a single moment, with each interviewee, after accepting and signing the Free and Informed Consent Form (FICF), being that it was recorded and, subsequently, transcribed to enable the data analysis, in order not to lose any information. The subjects were identified by codes from E1 to E8.

The analysis of the collected data from the interviews took place in three stages^{11:316-318}, namely: Pre-analysis, Material Exploration and Treatment of the obtained results and Interpretation.

This research was guided by the Resolution nº 196/96. The project of this study was submitted to the Ethics Research Committee from the Maria Milza Faculty, which issued an opinion for its approval (nº 038/2010).

RESULTS

We have identified different conceptions about the Humanization by the higher-level professionals who assume the management of the Family Health Units. The conceptions presented by the interviewees gave names to the categories of this study, namely: Humanization as care according to the demand/need; Care in accordance with the principles of the SUS; Humanization as welcoming; and, Humanization towards the relationships with the individual and with the team.

DISCUSSION

For discussing the results, we will adopt the categories that have emerged from the reading and analysis of the conducted interviews for the development of this study.

• Humanization as care according to the demand/need

For some interviewees, the humanization is summarized in caring of the user according to the presented demand/need. Thus, the humanization was expressed through the suppression of needs. Another interviewee understands that this service is also extended to co-workers:

[...] Understanding his need [...] based on the principle that I have to understand the demand of the other, and enjoy, welcoming this individual and providing care according to his demand. (E1)

You try to meet as much as possible the need of the person who searches for you, whether it is professional, employee or patient. That's to say, you got to hear the complaint. (E7)

These presented excerpts reveal a humanization based on the search for quality; this viewpoint has already been advocated even before the discussions about the PNH, when the SUS, as a right of the citizen, promotes the resolution of the health problems and encourages the life quality in the health work for the professional.

The issue of humanization appears in several realities and contexts, under various denominations, usually linked to the pursuit of the improvement of the care quality to the user, the request for qualification and expansion of the welcoming, resolution and availability of the services. On the other hand, the health workers seek better training and work conditions to satisfactorily deal with the intensity of the impact that the everyday confrontation of disease and suffering imposes them, as well as to face the challenges of care from the perspectives of universality, integrality and equity of the health care, which are recommended by the SUS.¹³

For achieving this resolution, it becomes necessary and essential to listen and record the demands of the users, by the professional, as a way of using a technology that allows it to investigate the problem beyond the complaint. This technology^{14:592; 8} refers to the listening, and is called “conversational technology”, which “facilitates the identification, preparation and negotiation with the users with regard to the needs that might be met in that or other institutional spaces”.

The understanding of respondents focuses on the resolution, based on the exposed demand, that from a qualified listening, a certain situation might be resolved. The professionals seek to identify the needs and, accordingly, the beginning of an individualized

therapeutic project is tested. This project is a set of proposals of articulated therapeutic conducts to an individual or collective target, resulting from the collective discussion.¹⁵ In reality of the Family Health Strategy, the project might be made for groups, families and individuals, in search for the uniqueness (the difference) as a central element of articulation.

Our viewpoint corroborates the respondents' perspective with regard to the listening to demands for seeking a unique and integral performance in the search for the resolution, i.e., in the quest for the care humanization. Nevertheless, this is one of the means for achieving the humanization, but does not translate it. This idea corroborates the authors who state that defining humanization is a process of multiple interpretations. According to the interviewees, this conception came from a practice of the daily work, the care based on the listening and resolution of demands.

• Care in accordance with the principles of the SUS

When asked about the concept of humanization, E2, E3 and E7 stated that humanization is to promote the principles of the SUS. This conception arose from several strands, but with the same meaning: promoting the integrality.

[...] It is a policy aimed to promote those principles that are upheld by the SUS! The user's accessibility, integrality, equity! (E2)

Humanization is we know how to treat the patient. [...] It is to treat the person in the same way that we would like to be treated. (E3)

[...] It happens when you promote those aspects of the SUS. The integrality, equity, good attendance [...] (E7)

The aforementioned interviews' excerpts reveal a practice that should be common, in which the user expects that its demand will be resolved and, according to the interviewees, the patient should be addressed with a purpose of investigating of the health-disease process and knowing the determinant factors, so that the multiple factors are identified and the health might be promoted.

The conceptions presented by the several study subjects corroborate the guidelines presented by the Brazilian Ministry of Health, when it states that Humanization as a cross-sectional policy of the SUS should “translate the principles of the SUS in modes of operation of the different devices and subjects of the health network”^{17:12}, and should “operationalize with the rescue of the basic fundamentals that guide the health

practices in the SUS”.^{3:19} The assessment and monitoring handbook of the PNH emphasizes the need to ensure access and integral care to the population and strategies to expand the condition of rights and of citizenship of people.¹⁸

Nonetheless, there is a risk of reducing the real concept of humanization, by translating it as integrality. Some authors^{19:392} corroborate this perspective when presenting the *methodological challenge* of humanization, by agreeing with other critics of the humanization process, when understanding that there is a repetition of the principle of integrality. Furthermore, they highlight that it would be not suitable to think of an “integrality policy”. Thus, a policy cannot be confused with a principle; and humanization as public health policy should accomplish the different principles of the SUS in the health practices.

The integrality here presented by the respondents is seen as the principle that is opposed to the fragmentary and reductionist approach of the individuals. The professional gaze, accordingly, should be totalizing, with seizure of the biopsychosocial subject that is inserted in a life context. Thus, it would be characterized by the care that pursuit to go beyond the disease and the manifested suffering, by seeking to understand the broader needs of the subject.²⁰

• Humanization as welcoming

The research subjects, when defining humanization, referred to the welcoming as the way to produce and implement the humanization:

Humanization is a new approach to deal with the population [...] it is based on the welcoming, change of professional posture [...] (E4)

The welcoming got to be implemented [...] the patient has to be treated in a humanitarian way ((E8)

As noted above, in the conceptions of E4 and E8, the humanization is a way to assist the user and, according to them, this whole process is based on the welcoming. The humanization as a new approach to which E4 makes reference drives us to discuss about a change of the care practice of the traditional model, which proposes a set of changes in the practices and organization of the health care. This reality is confirmed and presents the reorientation of the focus of care as one of the changes in the practices of health care, which “ceases to be the disease of an individual, generally understood outside of its social and economic context, and starts to be the family”.²¹

One of the ways to provide a humanized care in the context of Health Collective is through the welcoming of users.²² Consider the following statement:

Humanization is the whole process of welcoming the individual in that unit, from the reception, when the user arrives to be served (E5)

The activity of reception of a health service should be understood as a space in which there is the recognition of user’s needs by means of an investigation. Therefore, the welcoming would result in humanization when used as a tool to support the relationship between the team and the user, where the team is touched by its demand.²³

When the subject E5 states that the welcoming goes beyond the reception, by being exercised by all professionals of the team, responds through prerogative for the implementation of this device: the welcoming is a process that covers the entire therapeutic pathway of the user in the service. Thus, one can think of the welcoming as a process that begins with the entrance of the user in the institution and is extended until its departure. Hence, there is no specific time, or place for the process of welcoming, but rather an integral care that values the human being.²²

• Humanization towards the relationships with the individual and with the team

When the study subjects commented on their conceptions about the humanization process, emphasized that this is defined as a way of acting from the professional directed not only to the service user, but also for service professionals. This perspective supports the idea that humanization is a relational process and, before benefiting the user, should promote good relationships and good conditions in the work environment. The contents of the interviews exemplify this context:

Acting as a health professional, in an attempt of humanizing, not only the client, but the team that is working with me. (E1)

I think that the humanization is much more an issue of sensitization (...) both for the patient, [...] and also you are humanized in relation to the internal questions. (E7)

The speeches of the respondents demonstrate the viewpoint of health promotion, integral and humanized, based on a model of care that is grounded by the work organization in a multiprofessional team, in which the relationships are established with sights to promote greater team integration. This is considered an important strategy for reorganizing the work process towards a more effective and integral approach.²¹ These

authors, when discussing these changes in the health care, state that they do not occur naturally, neither automatically, thus requiring a new work organization that allows to deal, more widely, not only with the health of service users, but also with the health workers within this rearrangement of the work processes, by requiring greater breadth of skills and diversity of practices.²¹

With a view to achieve greater breadth of skills and practice, it is necessary that they are socialized among the members of the health team in a process of exchange and building of conducts based on the valuation and protagonism of subjects. Often, the professional working in a team cannot think of solutions or new ideas that singly transform the reality. For this purpose, the PNH has developed a device that creates collective spaces of discussion among the workers, which is defined as Humanization and Working Group (known as GTH).

Here, we draw attention to the importance of the executive managers of services as promoters and facilitators of a process of collective reflection on the work itself, within a space where all individuals have the same right to say what they think, criticizing, suggesting and proposing changes in the operation of the services, in the care to users and in the modes of management thereof. The humanization, accordingly, is promoted to the professionals when they perform self-reflection and recognize their importance within the group. Occasionally, this process ends up benefiting the user itself as it is the largest beneficiary in the process of health humanization.

FINAL REMARKS

This study has shown a plurality of understandings of health professionals about the humanization. We consider these findings as a positive aspect, since these conceptions might be used with sights to unify the ideas for the collective building of interventions within the local and municipal health coverage. The respondents have presented in each interview a capacity and interest in promoting the humanization, and this should be a feature to be used by managers as a driving force for the process of implementation and consolidation of the Humanization Policy in the services.

However, the ideas presented by each respondent are still reduced due to the breadth of the concept of humanization and the coverage of the Humanization Policy in force in our country. We realize that the understanding of humanization, according to

the executive managers, is linked in order to be translated into principles and guidelines of the SUS or in devices of the PNH. This is a mistaken viewpoint, since these principles and guidelines are intrinsic to the operation and organization of the services of the SUS, because the PNH has been developing devices and tools that, when reasserting the principles of the SUS and basing actions according to their guidelines, propose changes and reorganization in order to produce life quality for all individuals involved in health promotion and production.

Nevertheless, the results raise the reflection that the humanization is an essential pillar in the building of the new model of health care with the establishment of bonds among professionals /users/families and through the team accountability. It becomes clear that for starting a significant modification in the care model and, consequently, achieving the care humanization, it is crucial to redirect the organization and distribution of actions and services in order to satisfactorily answer the demands and needs of the health care.

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