ASSISTANCE PRACTICES OF RAPPROCHEMENT AND DISTANCING OF HUMANIZATION IN PRENATAL: AN INTEGRATIVE REVIEW

PRÁTICAS ASSISTENCIAIS DE APROXIMAÇÃO E DISTANCIAMIENTO DA HUMANIZAÇÃO NO PRÉ-NATAL: REVISIÓN INTEGRADORA

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ABSTRACT

Objective: analyzing the available evidences in the literature about healthcare practices in prenatal care for low-risk of rapprochement or distancing from the national policies and programs of humanization. Method: an integrative review with search in LILACS and SCOPUS database, using the keywords "prenatal care" and "primary health care". After reading the articles, in order to organize the collection and analysis of those who met the inclusion criteria was presented in a figure; yet, the articles were classified according to the seven levels of evidence described by Melnyk and Fineout-Overholt. Results: 18 articles were selected. In these, it was evident that the humanization of prenatal care presents a construction and reflection period, even present in the actions developed in healthcare practice. Conclusion: it is understood that there are many challenges and the need for studies and improvement in healthcare practice so there is the qualification of assistance. Descriptors: Prenatal Care; Primary Health Care; Humanization of Assistance.

RESUMO

Objetivo: analisar as evidências disponíveis na literatura sobre quais as práticas assistenciais na atenção pré-natal de baixo risco que se aproximam ou se distanciam das políticas e programas nacionais de humanização. Método: revisão integrativa com busca nas bases de dados LILACS e SCOPUS, com os descritores “cuidados pré-natais” e “atenção primária à saúde”. Após leitura dos artigos, a fim de organizar a coleta e análise dos que atenderam aos critérios de inclusão foi apresentado em uma figura; ainda, os artigos foram classificados de acordo com os sete níveis de evidências descritos por Melnyk e Fineout-Overholt. Resultados: foram selecionados 18 artigos. Nestes, evidenciou-se que a humanização no cuidado pré-natal apresenta-se num período de construção e reflexão, mesmo presente nas ações desenvolvidas na prática assistencial. Conclusão: compreende-se que são muitos os desafios e a necessidade de estudos e aprimoramento na prática assistencial para que haja a qualificação da assistência. Descriptores: Cuidado Pré-Natal; Atenção Primária à Saúde; Humanização da Assistência.

RESUMEN

Objetivo: analizar las evidencias disponibles en la literatura acerca de las prácticas de salud en la atención prenatal de bajo riesgo que se aproximan o se alejan de las políticas y programas nacionales de humanización. Método: revisión integradora con la búsqueda en las bases de datos LILACS y SCOPUS, utilizando los descriptores “atención prenatal” y “atención primaria a la salud”. Después de leer los artículos, con el fin de organizar la recogida y el análisis de los que cumplieron los criterios de inclusión se presentó en una figura; sin embargo, los artículos fueron clasificados de acuerdo con los siete niveles de las pruebas descritas por Melnyk y Fineout-Overholt. Resultados: 18 artículos fueron seleccionados. En estos, se hizo evidente que la humanización de la atención prenatal se presenta en un periodo de construcción y reflexión, incluso si están presentes en las acciones desarrolladas en la práctica asistencial. Conclusión: se entiende que hay muchos desafíos y la necesidad de estudios y mejora en la práctica de la salud por lo que es la calificación de la asistencia. Descriptores: Atención Prenatal; Atención Primaria de Salud; Humanización de la Asistencia.

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The uniqueness of pregnancy permeates the importance of looking and holistic care of women during this period. This phase is marked by changes influenced by historical, cultural, economic and social context that it is. Thus, prenatal care challenges health professionals to understand these peculiarities, providing care that addresses their real needs, ie, a humanistic, holistic view of pregnant women and their context.

Grounded in these pillars, emerges the term “humanization”, which outlines new guidelines on care. In humanized care, proves to be primordial aspects as: the provision of necessary resources, organizational routines with proven beneficial procedures, avoiding unnecessary interventions, and establishing relationships based on ethical principles, ensuring privacy and autonomy and sharing with woman and her family decisions on the measures to be adopted.1

In order to implement these assumptions humanization, the Ministry of Health through the national public policies and programs outlined a history of changes and renovations in assistance to women during pregnancy and postpartum period, seeking a differentiated and quality attention. The emergence of the term humanization casts a new light on the care given.

Specifically on the humanization of prenatal care, policies and programs those stand out are the Program for the Humanization of Prenatal and Birth (PHPN), created in 2000, and the National Humanization Policy (NHP) in 2003. Apart from the year 2006 the update of the technical manual, named Prenatal and Puerperium: Qualified and Humane Care. And, in 2011, the Stork Network rooted in the principles of humanization that proposes new strategies to describe maternal and child health.

In the present study, show up weaknesses in the implementation of these policies reveals that the expected coverage is far from desired. Reveal that humanization is still far from being achieved in most municipalities. Nevertheless agree that these are effective strategies of care, in view of improvement of national indicators, but for that to happen today reinforces the responsibility of those who produce health in all areas, whether national, state or municipal.2 Humanization is still a polysemic concept in health, in most cases, obscure the viability of healthcare practice.

It is reaffirmed the dichotomy between the laws and actions of health professionals whose practice is far from reality by the proposed programs and policies concerning the humanization of pregnancy and puerperium. It visualizes the process of humanization of prenatal care and exercise of health professionals are strongly associated in order to exercise these principles in practice that will provide higher quality of care, and its key role in the implementation process of humanization.3

It is emphasized some issues those should be seen as essential personal and professional commitments: to be attuned to new proposals and experiences of care with new, less invasive techniques, practice of evidence-based medicine with the look of attentive observer to inter-subjectivity, recognition that the active agent is pregnant and that pregnancy is not a disease and mainly adopt ethics as a basic assumption in professional practice.3

Revealed by the scenario, it is visualized the essential to understand the context of humanization in care practice in prenatal care. Accordingly, a summary and analysis of the knowledge produced about care practices associating them with the policies and programs of humanization in the prenatal care of low risk was performed.

The method used in this study is the integrative review, which is proposed by the Evidence-Based Practice, in order to deepen the knowledge on the subject. It is noteworthy that, through this strategy, professionals from different areas of expertise in health own the quick access to relevant research findings those justify the conduct or decision making, providing a critical knowledge and qualified making.4

With the aim of contributing to qualification of humanized care prenatal care, proposed the present investigation with the objectives:

- Analyzing the available evidence in the literature about healthcare practices in prenatal care for low-risk approach or distancing of national policies and programs of humanization.
- Identifying the strategies to minimize barriers in the humanization of prenatal care.

In line with the objectives of the study, it was opted for conducting an integrative literature review, in order to gather and synthesize research findings on a particular topic, allowing to identify gaps in knowledge
and the synthesis of multiple published studies. Being able to generate general conclusions about a particular subject or area of study, this can contribute directly to the qualification of nursing practice.⁴

During the preparation of this study, roamed the following steps: establishing the research question; establishing criteria for inclusion and exclusion of articles; categorization of studies, evaluation studies, interpretation of results, and synthesis of knowledge.⁴

As a starting point, the research question that guided this study is grounded in the following thought: <<What are the healthcare practices in prenatal care for low-risk approach or distancing from national policies and national programs of humanization?>>

The search was conducted on the basis of Latin American Literature and Caribbean data in Health Sciences (LILACS) and SCOPUS (Database of Research Literature). There were defined the descriptors “prenatal care” and “primary health care” to perform the search. As a timeframe, the year 2000 was due to the first part listed foundations using the term humanization, in the specific case, in prenatal care, being the Program of Humanization of Prenatal and Birth proposed by the Ministry of Health. Data collection occurred in June 2013.

The criteria for inclusion articles submitted complete abstracts in the databases were included, available online, for free, in its entirety, from original research, in English, Spanish or Portuguese languages, published between 2000 and 2012. It is also noteworthy that in this review were used only national studies, as the guiding question of this study relates the humanization of prenatal care from the perspective of policies and programs in Brazil. Articles those do not related to the studied topic and not answer the research question were excluded.

Based on the defined descriptors, the search on the database LILACS proceeded as following: “prenatal care” and “primary health care” [Subject descriptor] and Brazil [country, year of publication] and “2000” or “2001” or “2002” or “2003” or “2004” or “2005” or “2006” or “2007” or “2008” or “2009” or “2010” or “2011” or “2012” [Country, year of publication] and “Spanish” or “English” or “Portuguese” [Language]. In SCOPUS, “prenatal care” and “primary health care” [Title-abs-key] and Brazil [affilcountry] and “> 1999 < 2013” [pubyear] and “Spanish” or “English” or “Portuguese” [language].

There were found 57 articles, being 21 in LILACS and 36 in SCOPUS. It is noteworthy that even with the limitation of studies in the area was able to answer the research question, since this theme of humanization is current and the term “humanization” is relatively new in the studies. Accordingly, we sought to extend the search with the keywords “prenatal care” and “primary health care” and relate to concepts and proposed policies and programs to verify humane care practices related to this theme.

From these studies, 18 articles were selected for analysis, the remainders were excluded bases on the following criteria: the LILACS database, there was a clipping repeat; nine thematic clippings, a thesis, finishing with ten items. Already in SCOPUS, 20 were excluded in thematic focus, one for clipping incompleteness, seven cut repeat the two selected bases, ending with eight.

After reading the articles, in order to organize the collection and analysis of the articles that met the inclusion criteria, a summary table, adapted for this study, which includes the following was accomplished: intervention studied; the survey reference/code results (was listed as the guiding question identifying practical approach and distancing humanization); recommendations and/or conclusions. Also, studies were classified according to the seven levels of evidence described by Melnyk and Fineout-Overholt.⁶ The classification of items, the results were grouped in the following themes: Care practices approach with policies and humanitarian programs in prenatal care, promoting Practices distancing the assumptions of humanization; strategies to minimize barriers to humanize care.

RESULTS

It is presented below a universal overview of 18 selected articles in this integrative review. In the articles included it is visualized publications concentration of studies in Brazil (94,44%). The subareas of knowledge varied: Medicine (47,05%), nursing (47,05%), Nursing and Dentistry (5,55%) and Social Sciences (5,55%). Referring to the year of publication highlighted the publication of studies in 2012 (27,77%), followed by 2011, 2010, 2007, 2004 and 2000 (11,11%), and the year in 2008, 2006 and 2003 (5,55%).

Regarding the study scenario, studies predominated on health units (Basic Health Unit and Family Health Strategy) (66,66%). In a smaller proportion were found in the hospital area (16,66%), in the two spheres unit/hospital (5,55%). There were also...
considered in this review, studies from newsletters routing for high-risk pregnant women (5,55%) and the service from the mom card (5,55%).

Considering the subjects of the studies there were conducted with pregnant women (33,33%), women (22,22%), pregnant women and nurses (11,11%), and others: health team/pregnant and pregnant/health professionals different areas and finally nurse/doctor/engineer unit/pregnant women (5,55%). The publication in journals was observed in the following fields: Nursing (22,22%), Public Health (11,11%), Public Health (11,11%), medicine (5,55%) and Interdisciplinary (5,55%). Regarding the designs of the studies predominated the transverse/descriptive studies (55,55%), followed by studies of qualitative research (38,88%) and (5,55) the study did not mention the method, but it is perceived the descriptive organization of the same. Regarding the level of evidence, all items are evidence level six. Presents the following references of selected articles in full:

References/Code


In order to answer the research question of this review, the three themes arising from this study will be presented:

Care practices approach with policies and humanitarian programs in prenatal care: Among the actions developed in care practice that are associated with the approximation assumptions of humanization, were highlighted: host stimulus bond formation and qualified hearing professional front for pregnant women (A1, 3, 5, 10, 16); geographic features aiding in membership and access of pregnant women (A1, 7, 9, 18), job satisfaction developed by health and recovery of waste by the users (A1, 5, 16) ; autonomy and leadership of women in prenatal care (A1, 5, 17); Family Health Strategy as a model of care, with growing trend of health indicators and good coverage of actions (A2, 3, 7, 12, 13, 16, 18); indicators of progress in the quality of care and coverage compared to less than 2000 years (A2, 3, 17), use of technical manuals and protocols in healthcare practice (A4, 7, 10, 15, 16), need for multidimensional look for pregnant women (A5, 10), service accessibility, facilitators in capturing aspects of pregnant women and early prenatal care early on (A5, 7, 9, 10, 18, 13); professional responsibility of health and user (A5); based practice in epidemiological studies (A9), in the fields of university activity: the intensification of supervision and qualification records (A9); effectiveness of referral and counter services (A14); influence training...
under multidimensional look and without unnecessary interventions (A15), and qualifying facilities (A16).

It is emphasized that, although it is possible to list several factors of rapprochement to humanization, the reality presented in the studies, excel favoring a distancing humanization of prenatal care advocated for policies and programs. Even some studies revealing indicators that influence how adherence to the assumptions of humanization factors, these are also exposed as estrangement, as can be glimpsed below:

Promoting practices of distancing the assumptions of humanization: appreciation of the biomedical model (A1, 4, 5, 10, 13, 14); discontinuity of care/caster Professional (A2, 10, 14), lack of records or depreciation by professionals (A2, 3), low coverage/request tests recommended in the first query (A2, 6, 8, 9, 10, 11, 12, 13, 16, 18), low coverage of educational actions (A3, 10, 13, 14, 15, 17), difficulty of access and weaknesses in services, previewed in late uptake of pregnant women, difficulty in scheduling appointments, fragile guidelines (A3, 5, 6, 7, 9, 12, 14, 16); weakness in organization the service account: facilities, distributions of resources, administrative and structural (A6, 7, 9, 10, 13, 14, 18), lack of professional qualification/non-adherence to protocols (A4, 5, 8, 18); workload teams (A4); difficulty working in teams (A4, 10); geographical and financial barriers (A5, 6, 8, 11); disrepute in primary care, the public sector associate with poor quality care and overvaluation of the private sector by users (A5, 2, 18); obscure role of women and bond formation, as well as the emotional toll of pregnant patients with these obstacles (A6, 10, 14), absence of reference and counter (A10); high percentage of preterm infants with low birth weight (A13), and use of, objectionable, such as ultrasound (A10, 18).

Some of these studies made it possible to list strategies to minimize barriers in the humanization of care, in which the following aspects were considered: an opportunity for a professional qualification/continuing education (A1, 3, 4, 8, 12, 13, 14, 15, 18); strengthen the Family Health Strategy, as there are indicators of good coverage and importance of this model for paradigm shift (A2, 4, 5, 7); encourage the use of protocols (A3, 4, 11, 18); qualifying process work through actions that enhance the health professional (A7); promote communication between different levels of health care (A8); enable greater mobilization and community participation (A9); strengthen educational priority actions (A10); focus on studies that provide knowledge about the users of health services (A11) and ensure control and surveillance records to the assessment and monitoring of services by professionals (A3).

DISCUSSION

Healthcare practices approach to the assumptions of humanization in prenatal care reinforce the importance of creating a bond, acceptance, respect for the values and culture of women as essential aspects for adherence of pregnant women to prenatal care. Also highlight some challenges as the essentiality of developing educational and health promotion.7

In a study strengthens the adhesion and continuity of prenatal care by pregnant women when attention received from health professionals is grounded by horizontal dialogue, humanized listening, valuing the culture of each individual and the search for the role of the pregnant women.8

The Ministry of Health to focus on the term humanization, highlights the appreciation of the different subjects involved in the health production process, fostering autonomy, leadership and responsibility among these subjects they.1

As for the actions undertaken in the Family Health Strategy, it appears that the best results can be achieved in this context, since the inclusion of pregnant women in the formulation of the shares sum efforts in favor of a more humane practice of perinatal care and caregiver due the proximity of this service to context of the user.

By valuing the relational aspects, pregnant women consider that attention should be turned to an approach that realizes in its entirety, emphasizing the need for a stronger link with health professionals, strengthened in health facilities.9

Another important factor relates to the early identification of pregnant women to start prenatal care, is emphasized in the studies the role of community health agent, whenever possible, which should mediate the actions of health professionals across the health services and the community, in order to promote linkages and facilitate interpersonal relationships. Thus, as soon as the mother is inserted into the program, the greater will be the guarantees of quality in health care offered.10 Still, it is noteworthy that the triad of access, hosting and humanization is of vital importance to the quality of care provided to women, not only
During pregnancy and throughout your life. It also provides for the establishment of strategies in order to enhance the actions of health in primary care, to enforce the principles of the Unified Health System.  

It is noteworthy that prenatal overcomes specific procedures need to combine theory and adapt the conditions of life of each woman within their limitations and seek to develop an effective care to these women, and from this view one way to approach a humanized.

Despite the political and humanitarian programs turned to prenatal care contemplate desired aspects; the reality presented demonstrates weaknesses in different fields. In the synthesis of the dimensions, the lack of adequate physical space, which interferes with the accomplishment of the healthcare and educational activities as well as the lack of community participation, intersectionality, and reference and counter affect health actions, disintegrating the parties and the remaining look reductionist biomedical predominant.

There are shown in a study factors that reinforce the detachment of the humanization process, the weaknesses of prenatal services as the reduced number of preventive tests, reflecting the lack of effective communication between professionals and user. Also reflected in the services there are hardly any educational activities, compromising care, since this provides subsidies to increase knowledge and empower pregnant women.

Another obstacle to the process of humanization, regarding professional qualifications and lack of specific qualification, which can directly affect the population served, since the professional who does not have the profile to work in the area, possibly will have many difficulties in achieving projects or even to have one facing the needs of each woman look. Moreover, by undermining the membership the actions of public health services visualizes discredit this level of attention. Thus the pregnant women show preference for the private network, which occurs due to the belief attendance this be better than the public health system. SUS, in view of the user, is considered a disorganized health service, based on poor quality, requiring long waits and without warranties of care.

This review enabled us to identify strategies to minimize barriers in the humanization process. However, for these are implemented, different areas should be responsible in carrying out health actions. Faced with this scenario, it reinforces the need for the development of patient empowerment collective effort among managers, health professionals and community to implement public health policies that support their programs, and that the treatment of women occurs in a comprehensive and humane way.

The co-responsibility of the different spheres meets the principles of the NHS and assist in the pursuit of horizontality, which is expected to approximate the realities of the contexts for the implementation of programs such as PHPN. We agree with the authors to state that there is no standard valuation model to investigate aspects of quality and associated with poor adherence of professionals and pregnant women to recommend programs and policies of humanization procedures factors. Therefore, local studies should be encouraged, as it may help to direct the formulation of strategies that prepare and humanize the prenatal period, translating into a powerful tool for municipal management to evaluate the prenatal care provided to the population model to invest the reorganization of primary health care.

**CONCLUSION**

The results showed that the humanization of care in prenatal care presents a construction period and a reflective process in the face of actions taken in care practice. The foundations that are highlighted in the studies, with aspects of approaching these assumptions, are still obscure and superficial in the practice of professionals, as presented in the studies.

It is essential in the construction of the humanization process organizing different aspects such as resource allocation, training and updating professional, horizontality of care, interaction between health professionals and especially to understand the context of these women.

These are the challenges posed in the health policies and programs that need to be better discussed their actual deployment. When you crave a process of humanization is necessary to visualize the different levels involved in the composition of this trajectory and how these are interrelated, since the humanized care does not take place in isolation.

That there are many challenges and the need for studies and improvement in healthcare practice so there is the qualification of care is understood, noting that is closely linked to humanize qualify.
Furthermore, we question the inclusion of policies and programs of the Ministry of Health in healthcare practice and how health professionals come accessing and being qualified for these proposals. This scenario requires significant changes across the biomedical paradigm that dominates, resulting in inadequate attention weakening and, again, it is recommended that the humanization. Based on these considerations, there is the potential for research focusing on the political and humanitarian programs in prenatal care practice related to these health professionals in search of answers that allow investing in strategies to approach and/or minimization/exclusion of factors that promote the detachment of humanized care.

REFERENCES

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