

## Comprehension of community healthcare agents on the National Humanization Policy

*Compreensão de agentes comunitários de saúde sobre a Política Nacional de Humanização*

*Comprensión de agentes comunitários de salud sobre la Política Nacional de Humanización*



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### ABSTRACT

**Objective:** To identify the comprehension of Community Healthcare Agents on the National Humanization Policy (NHP), as well as to analyze whether they recognize healthcare actions developed in their daily lives, as those established by the NHP.

**Method:** Exploratory and descriptive qualitative research, conducted between June and September 2013, with 15 Community Healthcare Agents of the Family Health Strategy Program in a city located in the West of Sao Paulo state. The data collection was conducted through individual interviews, using a semi-structured script and submitted to content analysis.

**Results:** Two categories emerged: "Superficial knowledge: an obstacle to the construction of humanized care" and "Actions of humanized health: trying to get closer".

**Conclusion:** The basic concepts of NHP are part of the knowledge of these professionals, but the understanding they possess is superficial, which directly affects the actions provided to the community.

**Keywords:** Health. Public health policies. Community health workers.

### RESUMO

**Objetivo:** identificar a compreensão do Agente Comunitário de Saúde sobre a Política Nacional de Humanização (PNH) e analisar se esses agentes reconhecem as ações de saúde desenvolvidas em seu cotidiano como aquelas estabelecidas pela PNH.

**Método:** a pesquisa é descritiva, exploratória e qualitativa, realizada no período entre junho e setembro de 2013, com 15 Agentes Comunitários de Saúde do Programa Estratégia Saúde da Família de um município do Oeste Paulista. A coleta de dados foi realizada mediante entrevista individual e roteiro semiestruturado, e os dados foram submetidos à análise de conteúdo.

**Resultados:** emergiram duas categorias: "Superficialidade no conhecimento: um entrave para a construção do cuidado humanizado" e "Ações de saúde humanizadas: tentando chegar mais perto".

**Conclusão:** os conceitos básicos da PNH fazem parte do conhecimento desses profissionais, porém, o entendimento que eles possuem é superficial, o que repercute diretamente nas ações prestadas à comunidade.

**Palavras-chave:** Saúde. Políticas públicas de saúde. Agentes comunitários de saúde.

### RESUMEN

**Objetivo:** identificar la comprensión del Agente Comunitario de Salud sobre la Política Nacional de Humanización (PNH), así como analizar si el mismo reconoce las acciones de salud desarrolladas en su cotidiano, como aquellas establecidas por la PNH.

**Método:** investigación descriptiva exploratoria y cualitativa, realizada en período de junio a septiembre de 2013, con 15 Agentes Comunitarios de Salud del Programa Estrategia Salud de la Familia, de un municipio del Oeste Paulista. La recolección de datos fue realizada por medio de entrevista individual, guión semiestructurado y sometidos al análisis de contenido.

**Resultados:** emergieron dos categorías: "Superficialidad en conocimiento: una traba para construcción del cuidado humanizado" y "Acciones de salud humanizadas: intentando llegar más cerca".

**Conclusión:** conceptos básicos de PNH hacen parte del conocimiento de estos profesionales, sin embargo el entendimiento que éstos poseen es superficial, lo que incide directamente en las acciones prestadas a la comunidad.

**Palabras clave:** Salud. Políticas públicas de salud. Agentes comunitarios de salud.

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## ■ INTRODUCTION

The Unified Health System (SUS) has as guiding principles: universality, equity and integrality, and among the various policies that administer this system, there is the National Humanization Policy (NHP), established in 2003, based on the improvement of quality of life, prevention and promotion of health of the population, considering the social differences in an ethical and holistic manner, committed to the needs of users<sup>(1-2)</sup>.

To humanize is to value the subjects participating in the health production process, emphasizing the commitment to the care and user quality of life, prioritizing the strengthening of citizenship and respect for differences, requiring a new relationship between professionals, users and managers through the reorganization of work processes at various levels of complexity<sup>(2)</sup>.

In the context of care in the primary health care, the Community Health Agent (CHA) is an essential element for exercising activities within the family, being a direct representative of the care and educating agent, by engaging in the privacy of users and getting to know their needs. Therefore, they are considered a link between the community and health services, immensely contributing to the consolidation of health care<sup>(3)</sup>.

Thus, the role the CHA plays seems to be relevant as they are transforming agents of their community, who implements public health policies towards a society with greater access to health services<sup>(4)</sup>. Therefore, conducting studies that cover the knowledge of health policy is considered important, in addition to their performance given the consolidation of care qualified actions to SUS users.

Considering CHAs as a consolidation instrument of NHP, conducting researches on how they view the principles of that health policy and how to use it on daily work are important topics. This is because the policy aims at improving the quality of care and health management in Brazil, benefiting professionals, users and managers, strengthening the commitment to the rights of citizens, teamwork and commitment to the production of health and quality of life<sup>(5)</sup>.

Thus, this study was based on the following research question: "How does the CHA understand the principles of NHP on his/her daily work?", answering the following objectives: to identify CHA understanding on the NHP; to verify if the agent recognizes health actions developed in their daily lives such as those established by the NHP.

## ■ METHODOLOGY

Descriptive and exploratory study with a qualitative approach conducted with 15 CHAs; who worked for at least

one year in the Family Health Strategy (FHS) in a city of West of Sao Paulo state. The data were collected between June and September 2013, through recorded interview in a private place, according to the availability of each employee, using a semi-structured script, consisting of the guiding question: Tell me about what you understand about the National Humanization Policy.

When the participant showed difficulty to express him/herself, we used the following support questions: 1) Have you heard, read about or participated in any recommendation on the SUS Humanization Policy? If the answer to the first question was YES, the CHA was asked to answer the following questions: 2) In the view of the recommendation received on NHP, describe in detail how you understand this policy. 3) Related to what you described about the NHP, which health actions, established by this policy, do you perform in your daily work routine? In the interviews that CHA answered NO to question 1, we asked him/her to answer the following questions: 2.1) What do you believe is the National Humanization Policy (NHP)? 3.1) In view of this description, which health actions do you conduct to implement the principles of this policy?

For the analysis, the interviews were transcribed in full and submitted to thematic content analysis. In pre-analysis, the documents organizational phase, there was the brief reading, the choice of reports, formulation of hypotheses, the choice of files and development of indicators to substantiate the interpretation; the exploration phase of the material was to find groups and associations that responded to the study objectives, and thus categories emerged. The results from the analysis phase comprehended the time they were made inferences and interpretation of the results<sup>(6)</sup>.

This study met the requirements established by Resolution 466/12 of the National Health Council, and the project was approved by the Research Ethics Committee involving Human Subjects of the *Universidade do Oeste Paulista*, protocol No. 1355 and CAAE No. 08577812.5.0000.5515.

All participants signed a consent form in duplicate, and in the presentation of results to ensure the anonymity of the participants, the quotes/excerpts from statements followed the acronym CHA, and an arabic number corresponding to the sequence of the interview.

## ■ RESULTS AND DISCUSSION

Altogether 15 CHAs were interviewed, of which eleven were female and four were male, aged between 19 and 61 years. The average education time was 14 years of study and the time working in the FHS was 3.5 years on average.

## Superficial knowledge: obstacle to the construction of humanized care

In this category the findings were discussed to clarify the knowledge that CHA has on the NHP, considering the importance of this knowledge for professional development and care in humanized services.

Thirteen participants claimed to have knowledge regarding the National Humanization Policy, participating in lectures, journal readings and conversations with other health professionals. However, superficial knowledge regarding these principles emerged.

*[...] to appreciate quality, respecting the rights of all patients [...] Treating them equally in the extent of their inequalities, [...] is part of integrating sectors, accommodating the patient is not a role only for the receptionist, but for all health care professionals. (04 – 25 years, 05 years in the FHS).*

The interviewed 04 highlighted equity as an important prerequisite for humanized care when s/he mentioned respect for the rights of citizens as the duty of the CHA, emphasizing the need for involvement of all health professionals in carrying out the service.

Discussing equity is encompassing respect for the conditions in which all people have access to the rights guaranteed, but it is important to have supportive environments, ensuring health services at all levels of care, and opportunities on which make choices for a life with quality<sup>(7)</sup>.

Thinking about the NHP for CHA also caused questions related to the reception to emerge, which is a more human care instrument and decisive for both the user and for the own health care team. This aspect can be seen in fragments of interviews 05 and 15.

*This humanization that you mean would be the welcoming [...] is to better advise patients for them to feel better in the unit, welcoming when they arrive they feel they are in a familiar environment (05 – 46 years – 05 years in the FHS).*

*What I mean by humanizing that I was taught, not only with patients but also with co-workers. You have to know the side of patients and the side of co-workers [...] you have to know how to treat, speak, act [...] What I mean by humanization is the respect that comes back and forth (15-26 years – 05 in the FHS).*

By caring in an empathic and holistic manner, professionals raise the quality in health, they show interest in real

needs of the other. The statement of the participant 10 is evident the need to care for patients in integrality.

*Treating the patient as a whole, regardless of social class, race, color. Seeing them as a whole, not only as a disease or HIV (10 – 26 years – 05 in the FHS).*

*[...] It is to respect the population, they have their rights and we our duties and we have to guide them according to each necessity, we have to know how to act according to each situation, how to know if they need to see a doctor, social worker, psychologist (08 – 28 years – 03 in the FHS).*

Interviews 08 and 10 bring out the opportunity to view the user as a whole, basic principle of NHP, which considers the user an individual being connected to their social and family environment, which requires an equitable and humane care by all staff members.

In the above statements, the humanized look passes through empathic relationship, respect and identification with users, involving the affective, cognitive and behavioral mechanisms, and sensitivity against the time that the other is facing<sup>(8)</sup>.

CHA refer to the respect and humanized care when stated the needs of each user and the importance of promoting better resolution in the service. One of the participants who stands out is the 14 when it describes, simply, the patient with risk classification, recognizing it as the basic concept of health care.

*It respect the patients first, see who is more in need in an emergency and if you can get ahead [...]. Respect the schedule of people who have consultations [...]. (14 – 19 years – 01 in the FHS)*

It was observed that the interviews, even if CHA claim to have knowledge of the NHP, some conceptualize this policy in an inadequate and simplistic way, or report not being able to explain what it means. Thus, humanization is placed short of their real goals, hampering the consolidation of the guiding principles of a comprehensive and effective care. This understanding can be found in the statements 01 and 06.

*[...] we have some Public Health journals that I read about it [...] I believe that humanization is basically care, good service, you receive the person at the door, serve them well and guide, we shouldn't let anyone to leave without an answer [...] a person needs something and you give them something in addition to what he/she needed, she/he*

*leaves happily because she/he took something and that is it(01-61 years – 05 years in the FHS).*

*I do not remember what was said about humanization. I know the topic, but you know I don't remember everything, you know what I mean. I think it's kind of humanization of care, has a whole as you said, communication, isn't it? (06-43 years – 05 years in the FHS)*

The participant 01 states that he acquired knowledge about NHP through informal education, but to externalize the knowledge gained in their discourse, denotes superficial knowledge on the concept of humanization. A superficial understanding of the guidelines and assumptions of NHP can bring up a question about how much health actions are actually resoluteness. Understanding humanization just give “something”, as described in interview 01, it does not solve the real issues of the health needs of the population.

Thus, to minimize the problem professionalization and training of health professionals are necessary to generate professional and personal satisfaction, contributing to the construction of their identity and appreciation, as well as contribute to the development of the work<sup>(9)</sup>.

The risk of trivializing the humane care, emerging from superficial understanding of the public health policies, brings out difficulties in their work confused with welfare which would be humanized care, leaving the professional daily margin integral and effective care in health as a right of every citizen<sup>(10)</sup>.

Through the statement of participant 01, it was possible to infer the fragility of health services as the permanent health education, mainly related to discussions about the NHP as a means of qualification of health work. This fact can be seen when the participants states gain knowledge about humanization informally, through journals.

The statements of the participant 06 refers to the unknown, because CHAs who are inserted in the health sector generally lack experience, demonstrating the need for constant training and the incorporation of new knowledge in their practices<sup>(11)</sup>.

There were two participants who caught our attention as they said they had no knowledge of the NHP because when asked about what they thought about it, they presented simple concepts, however, consistent with the objectives established by the policy. In the statements below, participants believe that this policy seeks to approach the health care of users empathetically and with problem-solving actions.

*[...]The Humanization Policy, without taking time to analyse it, I think that may be the way for you to have more contact with the patient, find out more about his/her life, his/her family history and what is happening. (02-41 years – 05 years in the FHS)*

*I think it's how we deal with the population in relation to their rights, obligations, it is to seek the best way to make the service provided in the healthcare, welcoming and respecting the subject. (07 – 25 years – 05 in the FHS)*

Participants 02 and 07 consider bonding, respect and acceptance as essential. In this context, it is necessary to take an interest in each other and be committed to the resolution of the health needs because the practice of humanization in healthcare is an approach that favors building relationships of trust and team commitment to the user ensuring the great quality in healthcare<sup>(12-13)</sup>.

Thus, continuing education appears as an essential qualification process for the quality of care, promoting the development opportunity and conceptual maturity of health professionals about the new care guidelines<sup>(14)</sup>.

In short, in most statements it was identified that the subjects received information about the NHP, but failed to define it in a comprehensive and conceptual way what they understand about this policy. And this fact can help us to reflect on the way that this policy is developed in a professional ground. In this context, it is believed that nurses can help to minimize the problem considering that this professional is co-responsible for the continuing education activities. Accordingly, health services can be adjusted, according to the constant changes in the organization of the work process, contributing to the construction of more humanized and qualified health services.

### **Humanized health actions: trying to get closer**

When requesting examples of health actions developed by CHAs in the FHS, it was found that all study subjects had difficulties to provide examples of humanized actions or actions which were linked to this policy. Even superficially, the CHA understands the NHP, but the daily work makes the distinction between professional obligations and specific actions, which follow this policy, blurred. The statements composing this category deduces that the CHA believes that by empathetically fulfilling their professional duty, they are already providing humanized care.

*[...]we are always trying to get closer to the patient in order to help, our team tries to do activities to have a relationship*

*with the population, I know there's a lot of things in this humanization policy, but I don't remember them. (06 – 43 years – 05 in the FHS)*

For having superficial knowledge of the NHP, the participant 06 cannot distinguish their basic obligations such as health promoting agent, one of the requirements recommended by the NHP.

Many community health agents report feeling unprepared to exercise some of their duties because their training prioritized the practical part than the theoretical part. The latter is fragmented and undervalued, disadvantaging the views of FHS users by the CHA as an inseparable unit, being unique, comprehensive and holistic<sup>(15)</sup>.

*[...] we see what's going on, I think that's it, we go to their homes to vaccinate. [...] If any patient feel sick at home, we call the ambulance. That is basically what we do of the humanization policy. (09 – did not report the age – 01 year in the FHS)*

It can be seen in the statement 09, a deficiency in understanding the meaning of NHP, thus, humanizing is not solving immediate problems, but to establish a differential to the service and health care. Humanization is represented by the quality of care provided to the user and their family members, considering each person a unique being, giving him/her a personalized service with a close contact, respectful and less mechanistic, not just as a tool for resolution of problems within the health services occasioned by improper forms of care<sup>(16)</sup>.

*Yes, I develop humanization, I bring to treatment every time they need. When the patient comes here I care for the patient, when I visit, I give attention. I treat them as I would like them to treat me, I try to respect human being [...]. Beyond what we do, the patient wants us to do more. Example: Here, we provide people with a prescription, and they even want us to bring the medicine for them. (12 – 28 years – 01 year and a half in the FHS)*

In the statement from participant 12, the professional externalized a humanized care discourse when he/she says "... we care for patients, treating them with respect," but at the end of the statement, he/she reports that some patients are not co-responsible for their health, making it difficult to solve the practice of care recommended by the NHP.

The change of a health system centered on the disease to humans as a whole requires a new profile and practice in the work of health professionals, guided by the principle of

integrality. Consequently, the biggest concern is found in the gap between the professional training and the needs of users, as shared responsibility strategies should be built at the moment of care<sup>(17)</sup>.

*With patients, we advise them on tests, on the schedules of something they have to do here in the Health Unit. We talk to them about our health campaigns, we make appointments, the exactly time they should come. We go after late vaccines, preventive tests, so this is humanization. (13-40 years – 01 year in the FHS)*

*We identify cases of hypertension, diabetes, pregnant women, bedridden, elderly. And knowing if they are being well cared for, is to observe a complaint, going after the doctor, or nurse, or taking them to a physical therapist or nutritionist, so I think I'm playing my role in it. (02 – 41 years – 05 years in the FHS)*

Participants 13 and 02 show little understanding given the real goal of NHP. In their discourses we highlight the trivialization of care, in which humanized actions are not highlighted, appearing as a value to the practical actions of daily life, which impairs the quality, resolution and any application of NHP, and care becomes superficial and standardized.

Thus, humanization will be a reality in institutions only when the actors responsible for the care visualize this policy as a health care model, and the tools that can guarantee the effectiveness of this process are: continuing and permanent education, information exchange and participatory management<sup>(18)</sup>.

In the statement of the participant 15 is evident his/her effort to conduct a professional service with quality and humanization, however, his/her discourse also reveals little understanding of what is truly important for the construction of comprehensive and effective care.

*I believe I humanize my work, I try to be the least invasive as possible with patients, I try to know how they are, I go there and see how they are and then I change the subject of visits, because I have a script to follow in visits, but I change, because if the patient wants to talk about another subject, once I spent more than an hour just listening the patient. (15 – 26 years – 05 years in the FHS)*

The assumptions of NHP and its main guidelines contain as the final objective of humanized care, as the theory provides the organization of practical actions aimed at humanizing the work of health professionals. Therefore, the real understanding of this policy by the CHAs can contribute to the

organization of their work routine and also for the construction of specific actions that provide humane and effective care to the population assisted by this professional.

## ■ FINAL CONSIDERATIONS

The basic concepts of the National Humanization Policy is part of the knowledge of CHA, but the real understanding of the purpose of this policy is superficial. Most CHAs confuse their professional duties with those considered humanized, demonstrating that the lack of conceptual compression hinders the practical construction of humanized health actions.

This understanding could be evaluated with efficacy in this research, however, and as the study is territorially limited, these findings regards only to CHA of one city, and thus should not be interpreted in a general way.

Factors highlighted in this study, as poor training of community health agents about NHP and non-performance of health actions in a humanized manner, highlight the need for continuing education in relation to the NHP. It is believed that training aimed at building practical projects that define goals and objectives of humanized actions would allow greater understanding for CHAs on NHP and consequently a professional performance more consistent with the guidelines of humanization in health care.

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