Survey of humanization assessment indicators in a medical ambulatory in the interior of São Paulo

Avaliação de indicadores de humanização em um ambulatório médico no interior de São Paulo

Evaluación de indicadores de humanización en un ambulatório médico del interior de São Paulo

RESUMO

Objetivos: identificar os indicadores de avaliação em saúde de um ambulatório médico de especialidades e associar as variáveis socioeconômicas aos fatores do Índice de Humanização dos Serviços, na dimensão usuário. Método: foi realizado um estudo analítico transversal com abordagem quantitativa, no período de junho de 2019 a agosto de 2020, e utilizado o Índice de Humanização dos Serviços. Resultado: Participaram do estudo 171 usuários, 18 profissionais e três gestores. O Indicador Final do Índice de Humanização dos Serviços foi considerado "bom" (0,64); contudo foram encontrados déficits na visibilidade e impacto da política em todas as dimensões. Na dimensão usuário, desconhecer a Política Nacional de Humanização em Saúde, autorreferir-se "preto ou pardo" e baixa escolaridade foram fatores que interferiram negativamente na visibilidade da aplicação da política e na percepção das atividades lúdicas desenvolvidas no serviço. Conclusão: Este resultado reflete um serviço que, em geral, assiste ao usuário e defende adequados processos de trabalho, baseados nos princípios humanizadores.

DESCRITORES: Política de Saúde; Humanização da Assistência; Indicadores de Serviços; Relações Médico-Paciente.

ABSTRACT

Objectives: to identify the health assessment indicators of a specialized medical outpatient clinic and associate socioeconomic variables with the factors of the Humanization of Services Index, in the user dimension. Method: a cross-sectional analytical study with a quantitative approach was carried out from June 2019 to August 2020, using the Services Humanization Index. Result: 171 users, 18 professionals and three managers participated in the study. The Final Indicator of the Services Humanization Index was considered "good" (0.64); however, deficits were found in the visibility and impact of the policy in all dimensions. In the user dimension, not knowing the National Policy for Humanization in Health, self-reporting as "black or brown" and low education were factors that negatively interfered with the visibility of the policy's application and the perception of the recreational activities carried out in the service. Conclusion: This result reflects a service that, in general, assists the user and defends adequate work processes, based on humanizing principles.

DESCRIPTORS: Health Policy; Humanization of Assistance; Service Indicators; Physician-Patient Relations.

RESUMEN

Objetivo: Analizar los factores asociados a la mortalidad hospitalaria por COVID-19 en Mato Grosso en 2020. Métodos: Se consideraron los registros de hospitalización de marzo a diciembre de 2020, de pacientes con COVID-19 con edad igual o superior a 19 años. Los datos se obtuvieron del sistema del gobierno estatal y las razones de riesgo se estimaron utilizando el modelo de regresión de Poisson. Resultados: De los 17.523 registros de hospitalización por COVID-19, fallecieron 4.147 (23,7%), mayor riesgo de muerte entre pacientes de 40 años o más, negros-marrones, indígenas, alguna comorbilidad, que ingresaron en UCI, que no residir en la macrorregión central, y que fueron hospitalizados en junio y julio, los de mayor concentración de hospitalizaciones por COVID-19. Conclusión: Además de los factores individuales, la organización y preparación de la red de atención para atender los casos graves de la enfermedad se asociaron con el riesgo de muerte por COVID-19.

DESCRIPTORES: COVID-19, Mortalidad hospitalaria, Muerte, Atención de la Salud.

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Bruna Ozaki de Almeida
Graduanda do curso de Medicina da Faculdade de Medicina de Jundiaí.
ORCID: 0000-0003-0552-7509

Gabriel Talioli Rabelo de Lima
Graduando do curso de Medicina da Faculdade de Medicina de Jundiaí.
ORCID:0000-0002-4029-0124

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Maria Helena de Sousa
Estatística. Mestre em Saúde Pública pela Universidade de São Paulo. Doutora em Tocoginecologia pela Universidade Estadual de Campinas. Professora adjunta da disciplina de Pesquisa em Saúde do Departamento de Saúde Coletiva da Faculdade de Medicina de Jundiaí.
ORCID: 0000-0002-1788-4653

Ana Claudia Giesbrecht Puggina
Enfermeira. Doutora em Ciências pela Universidade de São Paulo. Professora adjunta da disciplina Pesquisa em Saúde do Departamento de Saúde Coletiva da Faculdade de Medicina de Jundiaí.
ORCID: 0000-0001-8095-6560

NTRODUCTION

The National Humanization Policy (PNH - Política Nacional de Humanização), published in 2003, instituted the construction of new paradigms or institutional models based on the principles of transversality, protagonism and co-management. Unlike other public policies, whose proposals are based on a rigid structure of "how it should be", the PNH suggests ways of making change, through collective effort. [1-3]

The principle of transversality, proposed in the PNH, involves exchanges of knowledge and experiences among all strata: users, health professionals and managers, integrating themselves into the system, constituting a health humanization network. This concept breaks with the hierarchical power and the verticalization of communications – the management and construction of health become a dialogue between all those involved, and the unilaterality of the lines of command is replaced by the plurality of knowledge. This integrated knowledge leads to the health of the common good. [4]

Protagonism involves awareness and repositioning of individuals about their roles in health spaces. Users and professionals, then, become co-responsible for building health in their territory, by questioning and evaluating the flaws present in the current system. All have autonomy over their reality and the reality of the collective. [5] Co-management is based on the power of the collective to produce new realities, opposing the prevailing individualism in contemporary society. [5-6]

Based on these principles, the guidelines of the PNH are formulated, which guide actions through the construction of devices: flexible material and immaterial processes that are inserted in the scenario aimed at changing health care and management. Among them are reception, humanization work groups, reference teams, matrix support and ambience projects. [7-8] The PNH is also directly inserted in the doctor-patient relationship, moving away from the biomedical and paternalistic model in which the patient is summarized in his organic simplicity and his autonomy is suppressed to the doctor as authority. In this way, the PNH is inserted in a communicative model with adherence to holistic principles and makes the patient co-participate in the therapeutic process, which converges to the improvement of the quality and resolution of the service. [9-11]

Faced with the importance of the PNH, there is a need to evaluate the practical application of this policy in health services. Health assessment is provided for in article 15 of law 8080 and determines the need for assessment and inspection of health services, in addition to the dissemination of collected data. [12-13]

Therefore, the objectives of this study are to identify the health assessment indicators of a specialty medical outpatient clinic and associate the variable age, gender, education, income, occupation and knowledge of the PNH to the Health Services Humanization Index factors in the user dimension.

METHODS

Cross-sectional analytical study with a quantitative approach carried out from June 2019 to August 2020. The study site corresponded to a medical specialty clinic in a municipality in the state of São Paulo, in operation for 22 years. It has three managers, 36 physicians, one nurse and two nursing technicians, in addition to the academic community of a teaching institution linked to this outpatient service.

To determine the sample size of users, the instrument was applied as a pilot in 10 users, in which the mean and standard deviation (mean of 0.801 and standard deviation of 0.307, with a coefficient of variation of 0.38) of the Health Services Humanization Index (IHS - Índice de Humanização dos Serviços de Saúde) were calculated. Considering a margin of error of 0.046 (15% of SD) and setting alpha at 5%, it resulted in a minimum sample size of 171 users, to compose the convenience sample. As for professionals and managers, all of these groups were invited, 36 physicians and three managers.

The same criteria proposed by the authors of the instrument validation article were determined as inclusion criteria for the research. [2] As an inclusion criterion for health professionals and managers, it was established: [1] to be professionals in the health area with secondary or higher education and [2] to be workers or managers of the institution with an employment relationship. For users, the following inclusion criteria were established: [1] being adults over 18 years old; [2] being followed up at the specialty outpatient clinic and [3] being aware and oriented in time and space and presenting adequate clinical conditions to answer the questionnaire.

The first instrument used was the questionnaire characterizing the participants of

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the health service, which has 11 socioeconomic variables in the user dimension, 13 variables in the work dimension and 8 variables in the management dimension. The second instrument used was the IHS, which assesses the perception of workers, managers and users on aspects of humanization in health services. It is a public domain instrument and the author authorized its use. It is divided into three dimensions (work, user and management). In total there are 53 items, divided into six factors in the work dimension, with 25 items; seven factors in the user dimension, with 18 items; and two factors in the management dimension, with 10 items. [2]

The instrument was built based on the PNH and was considered valid and reliable in the validation study. The instrument items are measured with a Likert-type ordinal scale, with four response options (completely disagree, partially disagree, partially agree and totally agree). The values 0, 3, 7 and 10 are assigned to these four categories, respectively, multiplying the number of responses in each category according to their respective values. All questions receive the same weight. These results are added and then the value obtained is divided according to the number of respondents for each variable (response frequency). From this result in each item, an arithmetic mean of the values of the items belonging to the same factor is performed. Thus, the domain of each factor is obtained. [2]

The construction of the index, starting from the values, was carried out through the application of the same methodology used for the construction of the HDI and using the formula proposed by the author to obtain the index of each factor. The values obtained belong to the interval between 0 and 1 and are interpreted through the following categorical scale: excellent (0.90 to 1); very good (0.80 to 0.89); good (0.60 to 0.79); poor (0.40 to 0.59); very bad (0.20 to 0.39) and very bad (0.00 to 0.19). Thus, when this value approaches 1, the index will indicate the best situation.

Finally, the index for each dimension was calculated, obtained by the arithmetic mean of the general indexes of the dimension's factors. The Final Indicator of the Health Services Humanization Index is the result of the arithmetic mean of the index for each dimension (user, work and management). [2]

During data collection, users were personally approached by researchers at the specialty outpatient clinic. Workers and managers were invited electronically. After explaining the research purposes, the participants signed the Free and Informed Consent Form (FICF) and answered the questionnaires compiled in an electronic form.

A descriptive analysis of the sample characteristics and the participants' responses was performed for each instrument item. The software used was SPSS/IBM version 22.0. To assess data normality, the Kolmogorov-Smirnov test was used. From the results of this test, parametric or non-parametric data analysis was performed.

The bivariate association between socioeconomic variables and IHS variables was performed only on items in which the sum of the number of negative scores (partially and totally disagree) was greater than 10% of the total responses in the item. The probability of type I error adopted in the tests was $p<0.05$.

The research received authorization from the institution and was approved by the Research Ethics Committee under opinion number 3,493,211. All participants signed the Free and Informed Consent Form.

RESULTS

In the User Dimension, a total of 194 users were invited to participate in the survey. Of these, 23 refused to answer the questionnaires, resulting in a sample of 171 participants.

As for the socioeconomic variables of the users, the majority were female (n=114;66.7%), married (n=95;55.6%), self-reported white or yellow (n=100;58.5%), Catholic (n=106;62.0%), from Jundiaí or neighboring municipalities (n=93;54.4%) and did not know the PNH (n=142;83%). Practically half of the participants were between 21 and 59 years old (n=86;50.3%) and engaged in household chores and family care (n=87;50.9%). Higher frequencies of users with education up to secondary or technical education were found (n=71;41.5%), retirees (n=55;32.2%) and with a monthly income of up to one minimum wage (n=60;35.1%).

In the Work Dimension, among the 36 forms applied, 18 were answered, resulting in a response rate of 50%. One form was eliminated because the participant chose not to complete the survey during its application.

As for the socioeconomic characteristics of the workers, most of the sample were between 21 and 59 years old (n=11; 61%), were married or cohabiting (n=15; 83%), Catholic (n=14; 78%), self-referred to be white or yellow (n=17; 94%), had more than one employment relationship (n=14; 78%) and did not know the PNH (n=11; 61%). The entire sample had higher education or was a specialist, worked as a doctor and had an assisting occupation. Higher frequencies were found among professionals who were born in the municipality studied (n=5; 28%) and who had been in their current position between 6 and 11 years (n=7; 39%). Also, the sample was equally divided between males (n=9; 50%) and females (n=9; 50%).

In the Management Dimension, all members of this category were invited to participate in the research, including three managers, who agreed to participate in the research and answered the questionnaires.

As for the managers' socioeconomic variables, most of the sample was female (n=2; 67%), aged between 60 and 86 years (n=2; 67%), had been born in the municipality under study or neighboring cities (n=2; 67%) and knew the PNH (n=2; 67%). The entire sample had schooling up to higher or specialist education (n=3; 100%), was Catholic (n=3; 100%), had no other employment relationships (n=3; 100%) and worked in this service for over 22 years (n=3; 100%).

Regarding the IHS, in the User Dimension, it was observed that in factor 1 most users could not clearly see the PNH in the service: they were not informed about the possibility of participating in the ins-

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Table 1. Description of user responses to the IHS instrument and General Factor Index, 2022.

	Variable	Totally Disagree		Partially Disagree		Partially agree		Totally agree		General index
		n	%	n	%	n	%	n	%	
FACTOR 1	I had access and opportunity to make complaints, suggestions or compliments	84	49,1	12	7,0	19	11,1	56	32,7	0,13
	As a user, I was informed about the possibility of participating in the institution's planning/elaboration/evaluation process	142	83,0	9	5,3	4	2,3	16	9,4	
	The institution provides a humanization device such as the Humanization Working Group, Reception with risk classification, ombudsman and others	117	68,4	11	6,4	25	14,6	18	10,5	
	The unit develops recreational and leisure activities aimed at users: visits by doctors of joy or equivalent, musical activities, etc.	128	74,9	9	5,3	20	11,7	14	8,2	
FACTOR 2	My service was carried out quickly and resolutely	3	1,8	10	5,8	45	26,3	113	66,1	0,93
	My treatment was carried out in a resolute manner, in order to reduce time and unnecessary actions	2	1,2	5	2,9	11	6,4	153	89,5	
	In case of need, I intend to use the services of this institution again. I would recommend this service to anyone who needs it.	0	0	1	0,6	1	0,6	169	98,8	
	I was welcomed in this unit	0	0	0	0	1	0,6	170	99,4	
FACTOR 3	I was treated in a dignified and respectful manner. The institution guaranteed the fulfillment of all my rights as a user	0	0	0	0	3	1,8	168	98,2	1

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	The institution is well signposted: all environments are signposted and it is easy to go to sectors where I need to go, but I did not know before	2	1,2	5	2,9	20	11,7	144	84,2	
FACTOR 4	I received all the information I need about my treatment and all my doubts were answered	2	1,2	1	0,6	5	2,9	163	95,3	0,85
	I received information about service hours, rules for companions, how to contact professionals in case of need	42	24,6	8	4,7	18	10,5	103	60,2	
FACTOR 5	During my service, information about my history and health problem was treated confidentially and confidentially	1	0,6	1	0,6	5	2,9	164	95,9	0,98
	My privacy was respected: I had control over body exposure and personal information	1	0,6	3	1,8	5	2,9	162	94,7	
FACTOR 6	The environments are always clean and sanitized, providing comfort and well-being	0	0	0	0	4	2,3	167	97,7	0,97
	The facilities and furniture are adequate and provide comfort and well-being during the stay in the service	2	1,2	2	1,2	14	8,2	153	89,5	
FACTOR 7	Professionals wear a badge and identify themselves by name. I always know who I'm talking to	3	1,8	16	9,4	25	14,6	127	74,3	0,84
	I know the team responsible for my treatment	6	3,5	7	4,1	53	31,0	105	61,4	

Source: author's data, 2022.

titution's planning and evaluation process, they did not recognize the availability of humanization devices or the carrying out of recreational and leisure activities by the service. It was the factor with the worst evaluation in the dimension, being classified as "terrible".

In factors 4 and 7, most claimed to have received information about opening hours, rules and how to call professionals in case of need, they felt well-informed about the treatment and identified the professionals responsible for their follow-up. The factors were classified as "very good".

In Factors 2, 3, 5 and 6, the data showed that users recognized the resolution of the service, trusted the service provided, were well received, attended in a dignified and respectful manner, they felt respected regarding secrecy and privacy during the service and recognized the environment as clean and adequate. These factors were evaluated as "excellent". (Table 1)

Regarding the IHS of the Work Dimension, in factor 1, there was an intense divergence between positive and negative partial responses; however, it was possible to infer that the institution did not adequately adopt the principles of isonomy and equity among professionals and the implementation of PNH devices was not a priority. Most agreed, at least partially, that the institution offered a career plan (55%), a safe work environment (72%), professionals were identified with a badge (77%) and tech-

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Table 2. Description of workers' responses to the IHS instrument and General factor index, 2022.

	Variable	Totally Disagree		Partially Disagree		Partially agree		Totally agree		General index
		n	%	n	%	n	%	n	%	
FACTOR 1	Service standards uniformly adopted for all professionals - principles of isonomy and equity	2	11	6	33	6	33	4	22	0,46
	The institution prioritizes the implementation of National Humanization Policy devices that humanize work	2	11	7	39	8	44	1	5	
	The institution offers the necessary technological resources to provide assistance	2	11	6	33	7	39	3	17	
	The institution offers a career plan, which allows me mobility and professional advancement	3	17	5	28	4	22	6	33	
	The institution offers a safe work environment for the provision of risk-free assistance	1	5	4	22	5	28	8	44	
	Professionals are always identified with a badge	1	5	3	16	8	44	6	33	
FACTOR 2	I feel fulfilled with my work	-	-	1	5	8	44	9	50	0,65
	Estou muito satisfeito com meu salário	4	22	8	44	6	33	-	-	
	I am very satisfied with my salary	1	5	2	11	8	44	7	39	
	I feel that my work is recognized and valued	1	5	3	17	10	55	4	22	
	I am satisfied with the type of management adopted in the service	-	-	2	11	5	28	11	61	
FACTOR 3	A chefia da abertura para discutir as sugestões	-	-	1	5	8	44	9	50	0,91
	A comunicação entre a equipe é eficiente. As informações são claras, às demandas e objetivos de trabalho	-	-	1	-	9	50	8	44	
	I have autonomy to organize and carry out my work	1	5	1	5	5	28	9	50	

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	My work environment is very clean	1	5	2	11	5	28	10	55	
FACTOR 4	The work environment is adequately signaled	-	-	2	11	10	55	6	33	0,78
	All necessary materials and equipment are available for the service	1	5	4	22	5	28	8	44	
	The number of workers is adequate to provide assistance in a humane way	1	5	2	11	6	33	9	50	
	There is a multidisciplinary integration between the teams. There are periodic meetings for the discussion and construction of therapeutic projects.	4	22	3	17	6	33	5	28	
FACTOR 5	I know the Municipality's care network as well as the area assigned to the institution where I work	-	-	-	-	13	72	5	28	0,58
	The institution develops actions to improve the quality of life and reduce stress at work	3	17	5	28	9	50	1	5	
	I know the organizational chart of the institution	-	-	1	5	7	39	10	55	
	I have the opportunity to participate in educational activities promoted at the institution	-	-	-	-	9	50	9	50	
FACTOR 6	I know how to identify the occupants of the institution's hierarchical levels (Leaders, Management, Coordinators, Supervisors, etc.)	-	-	2	11	4	22	12	67	0,92
	I always have the opportunity to make suggestions for improving the service.	-	-	2	11	12	67	4	22	

Source: author's data, 2022.

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nological resources needed to provide assistance were offered (56%). Similar to the result obtained in the user dimension, "adaptation to PNH" was the worst factor evaluated in the dimension. In factor 5, the majority agreed, at least partially, that the number of workers was adequate (83%) and claimed to have knowledge about the city's care network (100%). There was greater disagreement regarding the presence of multidisciplinary integration and actions to promote workers' quality of life. Both factors were classified as "poor". (Table 2).

In factor 2, most professionals agreed, at least partially, that they felt fulfilled with their work (94%), were recognized and valued (83%), was satisfied with the management of the service (77%) and had autonomy (89%), despite being dissatisfied with the salary received (66%). In factor 4, most agreed that the environment was clean and signposted, and the necessary material resources were available. Both factors were assessed as "good".

In factor 3, most agreed that the leadership was open to constructive discussions, communication between the team was efficient and the service management was committed to the sector. In factor 6, the majority knew the organization chart of the institution, had

Table 3. Description of managers' responses to the IHS instrument and General factor index, 2022.

	Variable	Totally Disagree		Partially Disagree		Partially agree		Totally agree		General index
		n	%	n	%	n	%	n	%	
FACTOR 1	The service provided at the unit is welcoming and resolute and based on user risk criteria.	-	-	-	-	1	33	2	67	0,54
	The unit's work processes are organized to meet quality requirements.	-	-	-	-	2	67	1	33	
	There is objective evidence that the health practices developed in the institution are effective and efficient.	-	-	-	-	2	67	1	33	
	Unit users have access to detailed information about treatment, financial data and medical procedures performed by the health team.	1	33	-	-	2	67	-	-	
	Government instances have as a priority the implementation of PNH devices.	1	33	-	-	-	-	2	67	
	In the service there is a horizontalization of the lines of command.	1	33	-	-	2	67	-	-	
	We have developed a policy to reduce queues and expand user access.	-	-	1	33	1	33,3	1	33,3	

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	The institution has access to financial resources to implement the provisions of the National Humanization Policy.	-	-	1	33	1	33	1	33	
FACTOR 2	Workers and users participate in the formulation and implementation of the management policy	1	33	-	-	1	33	1	33	0,23
	The unit's management logic prioritizes the implementation of the principles and guidelines of the PNH.	-	-	-	-	2	67	1	33	

Source: author's data, 2022.

Table 4. Statistically significant differences in the comparison between the IHS items and sociodemographic variables, 2022.

IHS variable – User dimension	Grades	Socioeconomic variable		TOTAL
		Complete education		
The institution provides humanization devices such as a humanization work group, reception with risk classification, ombudsman and others.		No study - Elementary 2	High School - Specialist	
	Negative	62 (84,9%)	66 (67,3%)	128 (74,9%)
	Positive	11 (15,1%)	32 (32,7%)	43 (25,1%)
	TOTAL	73 (100%)	98 (100%)	171 (100%)
Note: Yates Chi-Square Test with continuity correction (p=0,015).				
		Knowledge about PNH		
The institution provides humanization devices such as the Humanization Working Group, Reception with risk classification, ombudsman and others		Yes	No	
	Disagreement	15 (51,7%)	113 (79,6%)	128 (74,9%)
	Agreement	14 (48,3%)	29 (20,4%)	43 (25,1%)
	TOTAL	29 (100%)	142 (100%)	171 (100%)
Note: Yates Chi-Square Test with continuity correction (p = 0,004).				
		Conhecimento da PNH		
The unit develops recreational and leisure activities aimed at users: visits by doctors of joy or equivalent, musical activities, etc.		Yes	No	
	Disagreement	17 (58,6%)	120 (84,5%)	137 (80,1%)
	Agreement	12 (41,4%)	22 (15,5%)	34 (19,9%)
	TOTAL	29 (100%)	142 (100%)	171 (100%)
Nota: Yates Chi-Square Test with continuity correction (p = 0,003).				
		Self-reported color/ethnicity		
The unit develops recreational and leisure activities aimed at users: visits by doctors of joy or equivalent, musical activities, etc.		White or Yellow	Black or Brown	
	Disagreement	74 (74,0%)	62 (88,6%)	136 (80,0%)
	Agreement	26 (26,0%)	8 (11,4%)	34 (20,0%)
	TOTAL	100 (100%)	70 (100%)	170 (100%)
Note: Yates Chi-Square Test with continuity correction (p = 0,032).				

Source: author's data, 2022.

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the opportunity to participate in educational activities, knew how to identify the hierarchy and had the opportunity to make suggestions. Both factors were classified as "excellent". (Table 2)

As for the IHS of the Management Dimension, in factor 1 it was observed that most managers partially identified the PNH in the service through: the work processes organized to meet the quality requirements (the three managers); the effectiveness and efficacy of the health practices developed; transmission of information about treatment, financial data and medical procedures to users (two); and the horizontalization of the lines of command (two). However, most of the sample fully agreed with regard to the service being welcoming, resolute and based on risk criteria, and also about government instances prioritizing the implementation of PNH devices. The sample differed regarding the presence of a policy to reduce queues and expand access. The factor was classified as "poor".

In factor 2, the sample diverged in assessing the impact of the PNH guidelines on the service: access to financial resources to implement the PNH devices and the participation of workers and users in carrying out the management policy were the items with the greatest divergences. However, most stated that the implementation of the principles and guidelines of the PNH was, at least, partially prioritized by management. The factor was classified as "very bad". (Table 3)

Finally, from the arithmetic mean of the general index of each dimension - IHS of the User Dimension of 0.81 (classified as "very good"), IHS of the Work Dimension of 0.72 (classified as "good") and IHS of the Management Dimension of 0.38 (classified as "very bad") - a value of 0.64 was obtained for the final indicator of the IHS, categorized as "good".

As for the bivariate analysis, only the items in which responses with negative scores (partially and totally disagree) greater than 10% of the total responses in the user dimension were found, this statistical treatment was applied. The IHS items of factor 1, 4 and 7 were compared with the variables: age, gender, education, color, income, occupation and knowledge of the PNH.

Four statistically significant comparisons were found, all in Factor 1. In the association of the item "The institution provides humanization devices as a Humanization Working Group, reception with risk classification, ombudsman and others" with education (p=0.015) and knowledge of the PNH (p=0.004), it was observed that most of the responses with negative scores were given by individuals who were unaware of the PNH and positive scores were given by individuals with higher education.

In the association of the item "The unit develops recreational and leisure activities aimed at users: visits by doctors of joy or equivalent, musical activities, etc." with knowledge of the PNH (p=0.003) and color (p=0.032), it was observed that most responses with negative scores were linked to the group of individuals who did not know the PNH and positive scores to users who referred to themselves as "white and yellow". (Table 4)

DISCUSSION

The general index of the user dimension was classified as "very good", while in another study carried out with the same instrument the result obtained was "good". In addition, the visibility and adaptation of the PNH in the service was framed as "terrible", similar to the study by Souza et al. [2] It is possible that the lack of knowledge of the PNH by most of the studied sample may contribute to greater difficulty in identifying the policy in the service, as observed in the bivariate analysis. It is important to emphasize that the presence of humanizing devices is not synonymous with visibility, since this depends on multiple factors of the different actors involved in health production. [2]

For example, in the results of the present study, the influence of the users' education was observed in the answers with positive scores in relation to the offer of institutional humanization devices such as work groups, reception with risk classification and ombudsman. In another study, carried out with another instrument, the researchers observed that individuals with less education had lower scores in a test that assesses health literacy. [14]

The service welcomes and meets the demands of its users, offering principles present in the PNH such as resoluteness, trust and bond building, factors that, in other studies, were associated with the production of more comprehensive care in order to meet the health needs of the population. [15-16] Effective communication needs to present a discourse adapted to the social and cultural realities of the population and encourage questioning and exchange of knowledge, practices that were recognized by users. [17] The patients' personal data are treated in a confidential and confidential manner, in compliance with the precepts present in the Charter of Users' Rights of the Ministry of Health. [18] The transforming principles of ambience advocated by the Ministry of Health are present. [19] These results are similar to those found by Souza et al. [2] and reveal that the PNH guidelines are represented in the service, despite its low visibility.

The general index of the worker dimension was classified as "good". However, again, the visibility of the PNH is deficient, especially with regard to the implementation of humanizing devices, in line with what is reported in the user dimension. However, most of the sample of workers was also unaware of the PNH, a fact that possibly influenced the negative result.

Other authors concluded that health work is often permeated by contradictions and dangerous situations for mental health. As a result, medical workers who participate in the production of health for individuals and the community may lose or degrade their own he-

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alth and quality of life. Therefore, this process can have a direct impact on the professional's performance in terms of care. [20]

Despite this, the professional feels recognized and valued for his work, conditions that increase the possibility of creating transformation movements in the services. [21] There is openness between the teams and management for communication and discussion, allowing for the maintenance of a participatory management; strengths, therefore, of the democratic participation of workers in activities and management of the service, in accordance with the proposals of the PNH. [3] Parallel actions that promote the necessary resources to provide care must be implemented to improve the quality of health services. [22]

The general index of the management dimension was classified as "very bad", in contrast to the result of the study by Souza et al. [2] In line with the other dimensions, the visibility of the PNH is impaired. It is observed that managers disagree with each other mainly regarding the presence of transversality of care, a deficit also reported by users. The PNH advocates the establishment of democratic management models, as opposed to the old vertical model, operating together with users and workers. [3]

CONCLUSION

In general, and especially in the user dimension, it is observed that the participants do not recognize the PNH in the service, although they identify the presence of some of its guidelines. Workers report the presence of transversal management, although users and even managers disagree. The scarcity of certain humanizing devices is clear.

The final IHS was classified as "good", despite specific points to be worked on. This result reflects a service that, in general, assists the user and defends adequate work processes, based on humanizing principles. The study was carried out in a single health service and with a small sample.

Faced with this, the need for further studies is highlighted, in other contexts and analyzing other factors, for reflection on Humanization, considering its importance and complexity.

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