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HOSPITAL HUMANIZATION FROM THE PERSPECTIVE OF THE SOCIAL WORKER

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ABSTRACT

Humanization in hospital care is a broad and complex theme, but of fundamental importance today, since we are witnessing a time of more fragile and superficial interpersonal relationships, reinforced by the appreciation of scientific and technological advances in the health area. The objective of this research was to identify the perception of the Social Worker in the process of Humanization in the hospital environment, in the city of Passo Fundo, Rio Grande do Sul. The contribution of this study is to identify the knowledge of the main characteristics of this process, identifying the contributions and difficulties

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Revista ARACÊ
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encountered by the Social Worker professional in the hospital environment. To this end, an exploratory and qualitative research was carried out, which made it possible to identify the process of hospital humanization in the view of this professional, in addition to being a qualitative research, with the data collected through semi-structured interviews, aiming at deepening the analyzed reality. According to the interviewees, social service professionals need to develop an articulating role, especially in the humanization process within hospitals, acting in an articulated way with the networks and the various professionals inserted in this area. The strategies and work possibilities are guided by the improvement and search for improvement in service, in its broadest form, but also aims at the care and recognition of the particularities of its users.

Keywords: Social Worker. Humanization. Hospital.

Revista ARACÊ
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INTRODUCTION

In recent decades, the theme of humanization has acquired an increasingly significant space in theoretical reflections and professional practices in the health sector. In a context characterized by technological and scientific advances, there is a need to rescue ethical and human values in the relationships established between health professionals, users and service managers. In this scenario, humanization is considered an essential strategy to improve both care and management of health services, promoting active listening, welcoming, and respect for human dignity (Oliveira, 2019).

The consolidation of the National Humanization Policy (NHP), instituted by the Ministry of Health in 2004, emphasized the relevance of sensitivity, bonding, and co-responsibility as pillars of care, evidencing the central role of health professionals in the construction of more humane and integrative practices. This policy proposes a new logic of care centered on the subject and on the valorization of health workers, configuring itself as a milestone for the reconfiguration of institutional practices in public health in Brazil (Brasil, 2004; Ayres apud Jung, 2007).

However, the excessive emphasis on technique and the objectification of the body in diagnostic and therapeutic processes often results in the depersonalization of care. As Baches, Filho and Lunardi (2006) warn, the disease began to be treated as an object isolated from the subject who experienced it, generating a rupture between technical-scientific knowledge and the human experience of the disease. This dissociation highlights a gap between biomedical advances and comprehensive care, compromising users' right to dignified, ethical and humanized care.

In addition, the precariousness of the working conditions of health professionals, especially those who work in public services, together with the overload of care, the scarcity of human and material resources and the fragility in the management of services, has aggravated the difficulties in operationalizing the principles of humanization in the hospital routine. These factors directly impact the quality of care and the possibilities of building bonds between professionals and patients (Damasceno, 2022).

In view of this panorama, it is crucial to investigate how the concept of humanization has been understood and put into effect in health institutions, particularly in the hospital environment, where fragmented and technicist practices predominate. In this context, the role of the Social Worker stands out, a professional who has contributed significantly to the

Revista ARACÊ
ISSN: 2358-2472

implementation of public policies and to the guarantee of the social rights of users, acting as a mediator between social and institutional demands (Oliveira, 2019).

Social Work, guided by its ethical-political project and by the principles of health reform, assumes humanization as a strategic field of action. From this perspective, the Social Worker seeks to incorporate into the work process a critical view committed to the defense of life, equity and citizenship, proposing interventions that transcend bureaucratic aspects and contribute to the transformation of institutional practices (Oliveira, 2019).

In this sense, it is essential to understand the multiple conceptions of humanization that coexist in the hospital environment, considering that these conceptions reflect different theoretical, political and ethical matrices. For the Social Worker, this understanding is fundamental, since his actions must articulate the principles of the PNH with social rights and with the professional commitment to social justice and equity (Brasil, 2003; Damasceno, 2022).

Therefore, this research aims to analyze the view of the Social Worker in the hospital humanization process, identifying how this professional interprets and applies the principles of the National Humanization Policy in their daily practice, as well as the challenges and potentialities of this action to build a more ethical, solidary and subject-centered care.

THEORETICAL FRAMEWORK

This chapter addresses topics related to the National Program for the Humanization of Hospital Care; National Humanization Policy (with sub-item Working Group on Humanization); Humanizing actions and strategies and continuing education as a principle of hospital humanization.

NATIONAL PROGRAM FOR THE HUMANIZATION OF HOSPITAL CARE

It was after the creation of the National Program for the Humanization of Hospital Care (PNHAH), in 2000, according to the Ministry of Health's Ordinance No. 881/2001, that the term humanization began to gain greater public visibility, although there were already other programs, projects and actions of a humanizing nature. Developed through the work of mental health professionals and the support of the then Minister of Health José Serra, this program was also a response to the results of the evaluation of the survey carried out with users of public hospital services, which revealed dissatisfaction and numerous complaints regarding the care provided (Brasil, 2000).

Revista ARACÊ
ISSN: 2358-2472

In the evaluation made by the users, the way they were being cared for, the ability shown by the professionals to identify their expectations and needs, became more important and relevant than the absence of medicines, doctors and the lack of physical space (Brasil, 2000).

The process of implementing the PNHAH began through a Pilot Project, implemented in ten hospitals, located in different regions of the country, and had the purpose of promoting a solid process of humanization of services with a view to producing progressive and permanent changes in the culture of care in order to obtain subsidies for the project to be disseminated to the other hospitals of the public health network in the country (Brazil, 2000).

According to a report by the Ministry of Health (2002), after five months of experience in the application of the pilot project, the response obtained was positive on the part of the hospitals, with acceptance by the users, demonstrating failures in the services provided, raising the need to develop a new culture of care.

According to the PNHAH, there were three essential axes for the development of the humanization process that should be followed: participatory management, training of the GTHs and participation in the National Humanization Network. The program also proposed five relevant steps in this process: sensitizing hospital management, making a situational diagnosis of the hospital institution in terms of humanized service, constituting GTHs, elaborating and implementing an action plan in humanization and evaluating the results of the humanization process (Brasil, 2000).

NATIONAL HUMANIZATION POLICY

In 2004, humanization actions were reformulated and unified, and the Ministry of Health launched the National Humanization Policy (PNH), also known as humanizes SUS. From this moment on, humanization is no longer seen as a program, but rather as a transversal policy that proposes to go beyond all levels of action and care of the SUS, unlike the PNHAH, which was directed to the hospital institution, it is based on the construction and exchange of knowledge, on dialogue among workers, teamwork and on the recognition of needs, desires and interests of the different actors in the health area (Brasil, 2004).

The PNH aims to contemplate the service provided to users, and, above all, the relationships between workers and managers, where:

Revista ARACÊ
ISSN: 2358-2472

> The great bet of the PNH is the inseparability between management and care, understanding that the management of health work processes cannot be considered as an administrative task separate from care practices (Paulon & Elahel, cited by Quintino, 2008, p. 32).

The principles that guide the PNH are: transversality, inseparability between management and care, protagonism, co-responsibility and autonomy of collective subjects. The guidelines consist of: expanded clinic, welcoming, co-management, valuing work and workers, fostering groups and collectives, defending users' rights and building the memory of the SUS that works (Brasil, 2008a).

The implementation of the PNH aims to consolidate and guarantee five specific points, namely: i) Queues and waiting time will be reduced with increased access and welcoming and problem-solving service based on risk criteria; ii) Every SUS user will know who will be the professionals who take care of their health and their health services will be responsible for their territorial reference; iii) The health units will guarantee information to the user, the monitoring of people in their social network and the rights of the Code of Users' Rights; iv) The health units shall guarantee participatory management to their workers and users, as well as permanent education for the workers, in the adequacy of the environment and healthy and welcoming work spaces (...); and, v) Activities to value and care for health workers will be implemented (Brasil, 2008a, p.31).

Thus, it is expected that, as well as the expected results and the devices activated, methods of monitoring and evaluation of the processes developed with a formative, participatory and emancipatory perspective will be used, as an evaluation instrument to ensure the effectiveness of the National Humanization Policy.

WORKING GROUP ON HUMANIZATION

The GTH is a device created by the PNHAH (National Program for the Humanization of Hospital Care) and maintained by the PNH (National Humanization Policy), which aims to intervene in the improvement of work processes and the quality of health production. This group includes people interested in discussing services provided, the dynamics of work teams, as well as the relationships established between health workers and users (Brasil, 2006a).

The GTH aims to create a meeting space, providing moments of reflection and sharing of thoughts and information, seeking improvements in actions aimed at the care

Revista ARACÊ
ISSN: 2358-2472

and functioning of the services provided, excellence in care and promotion of the health of its users, so:

> the construction of a working group brings people together, enables the transformation of the bonds already established, in addition to establishing a favorable environment to share the tensions of daily life, the difficulties of work, to welcome and debate divergences, dreams of change and to seek, through analysis and negotiation, to enhance innovative proposals (Brasil, 2006a, p. 6).

In this sense, a Humanization Working Group, in addition to creating, implementing and developing humanization projects, should constitute a space that provides the development of actions aimed at users, and working conditions for professionals, strengthening spaces for the exchange of knowledge aimed at improving the quality of the work developed, and consequently better results in the services provided to users.

The GTH is present in all the productions analyzed that address this process, such groups are composed in a very heterogeneous way and, according to Brasil (2006a), workers, technicians, managers, coordinators and users can participate in the GTH, in short, all those involved in the construction of proposals to promote humanization.

HUMANIZING ACTIONS AND STRATEGIES

When approaching the concept of humanization in health, it is possible to understand it from two interdependent axes: actions aimed at health service users and those aimed at professionals in the area. This distinction is in line with the guidelines of the National Policy for the Humanization of SUS Care and Management (PNH), formerly known as the National Policy for the Humanization of Hospital Care (PNHAH). The PNH contemplates the health service from two complementary perspectives: the humanization of public care, which refers to the care of the user, and the humanization of working conditions, which includes the care of professionals (BRASIL, 2001, p. 54).

With regard to actions aimed at users, user embracement stands out as one of the main humanization strategies. As established in the PNH booklet, reception is not limited to a specific physical space or a designated professional, nor to a fixed time. It is, mainly, an ethical and relational posture based on the commitment to attentive listening, co-responsibility and problem-solving. In this context, welcoming implies "sheltering and sheltering" the other in their needs, anxieties and particularities, recognizing them as subjects of rights and attention (BRASIL, 2009b, p. 19).

Revista ARACÊ
ISSN: 2358-2472

Another relevant dimension of the humanization process refers to the environment. This strategy includes the adaptation of physical spaces, such as the reorganization of furniture, painting of the walls, and the restructuring of service environments. According to the PNH, the environment refers to the treatment given to the physical space considered as a place of social, professional and relational interaction that should promote care, welcoming, and well-being for both users and workers. Therefore, it encompasses not only material and architectural aspects, but also aesthetic and sensory elements that impact the perception of care (BRASIL, 2009c).

Although improvements in the environment benefit both professionals and users, it is important to emphasize that they should not be confused with welcoming. Welcoming is a central guideline of the PNH because it involves ethical, aesthetic and political dimensions. Ethically, it implies recognizing the other in his totality and diversity; aesthetically, it requires the creation of strategies that value life and daily encounters; politically, it presupposes a collective commitment to active listening, the establishment of bonds and the transformation of relationships in health services (BRASIL, 2009a, p. 6).

With regard to humanization actions aimed at health workers, the PNH proposes specific guidelines for the hospital context. Among these, the following stand out: a) the implementation of systematic training and continuing education activities that constitute a permanent education project based on the principles of the PNH; b) the development of actions that promote care for workers, valuing their health, well-being and quality of life in the work environment (BRASIL, 2006, p. 32).

In order for professionals to be able to perform their duties with dignity and ethical commitment, it is essential that they be treated with respect in their human condition. This requires adequate working conditions, fair remuneration, and recognition for their initiatives and contributions to the care process (Backes; Son; Lunardl, 2006). Thus, it is observed that strategies aimed at valuing health professionals are essential not only for their individual well-being, but also for improving the quality of the care provided. Respect for the dignity of workers directly reflects on the effectiveness of health actions, enhancing more humane, welcoming and problem-solving practices.

> The well-trained individual, respected as a professional and as a person by the institution to which he belongs, with space to be heard in his doubts, anxieties and needs, and with conditions appropriate to the demands of his work, is better able to serve with efficiency and quality (Brasil, 2002, p.50).

Revista ARACÊ
ISSN: 2358-2472

As a result, the health and well-being of health workers are anchored in a recent standard, which is the Regulatory Standard for Occupational Safety and Health in Health Establishments (NR 32), Ordinance No. 485, of November 2005, (amended by Ordinance GM1,748, of August 30, 2011). NR 32, referring to Occupational Safety and Health in Health Services, has the purpose of establishing the basic guidelines for the implementation of measures to protect the safety and health of health service workers, as well as those who carry out health promotion and care activities in general.

In this sense, NR 32 has been considered extremely important in prevention and occupational health. If followed correctly, it aims to prevent accidents, and aims to improve the quality of work with a focus on reducing environmental, physical and chemical risks in the work environment. More and more mechanisms, laws and standards are being created to guarantee and improve the quality of life of health workers, but it is up to managers to encourage continuing education, creating spaces for dialogues and training aimed at the safety of their workers.

CONTINUING EDUCATION AS A FUNDAMENTAL PRINCIPLE OF HOSPITAL HUMANIZATION

The institutional changes and technological advances that occur over time increase the need for training Health Professionals to work within this new context. Nowadays, it is necessary for professionals who work with human beings to acquire skills to serve them through concepts and distinctions, in which health professionals can and should focus in depth.

In the same vein, new paradigms emerge to support this need, both for health professionals and for professionals who work in the area of education focused on the health area, seeking to train professionals from the perspective of the various developments of the action of educating, ensuring that they train professionals capable of being agents of transformation of reality.

According to Feuerwerker (2007), critical reflections on health education have been present on the agenda of certain movements for almost 50 years. Initially, it was only a few times, today, due to a series of elements of the political and economic context in the scope of both public policies and the private sector, there are significant contingents of teachers, students and health managers involved in initiatives for change.

Revista ARACÊ
ISSN: 2358-2472

The concept of Permanent Education in Health was adopted to dimension this task, not in the prolongation of the time or career of the workers, but in the broad intimacy between training, management, attention and participation in this specific area of knowledge and practices, through the intercessions promoted by health education (education intercedes for health, offering its constructivist and teaching-learning technologies).

The concrete exercise of this goal is carried out with public policy in an unprecedented way in the country, based on the approval by the plenary of the National Health Council (CNS), agreement in the Tripartite Inter-Management Commission (CIT) and legitimization in the 12th National Health Conference (Sérgio Arouca Conference), of the National Policy of Permanent Education in Health, presented by the Department of Health Education Management (Deges). of the Ministry of Health (MS), in 2003.

The indisputable novelty was made by the concrete formulation of a health education policy (a term that did not exist until then), surpassing the programming of training and updating of human resources; for its approval through six months of public debates and negotiations with the bodies already legitimized in the SUS; by the singular and concrete inter-ministerial approximation between Health and Education (the beginnings of an agenda dreamed of historically, and of extremely difficult feasibility) and, also, by the interposition of a new instance/new device in the SUS (intersectoral character, thematic focus, local and regional scope and inter-institutional structure). Creating a new instance/new device is not a formal act, but a construction act (Ceccim, 2005, p.1).

In view of this new reality, a new profile of professionals working in the health area is required. This constantly changing reality shows the need for health professionals to demonstrate skills and competencies in "knowing how to do" and "doing well". Thus, the professional needs to be prepared to act competently in the face of the various realities that are present in their daily lives, so that a complete initial training is not enough to meet the needs present in professional practice. Based on evidence, professionals need to constantly update their scientific knowledge, keeping up with technological changes to be able to improve their knowledge in practice, and ensure quality care in the hospital area.

In this sense, it is possible to observe the fundamental importance of continuing education to improve the result in the care offered by health professionals in the hospital environment. It is therefore worth briefly discussing the motivational factor that leads these professionals to voluntarily seek to update their knowledge and skills.

Revista ARACÊ
ISSN: 2358-2472

From this perspective, according to Ricas (1994, p.12), continuing education "would encompass teaching activities after the undergraduate course with more restricted qualities of updating, acquisition of new information and/or activities of a defined duration through the traditional methodology". For Nunes (1993), continuing education is characterized by educational alternatives that are not centered on the development of groups of professionals, which can be through complementary courses, or through specific publications in a given field.

METHODOLOGY

Research can be considered as a human activity that has the purpose of discovering answers to significant questions through the scientific process. In this sense, for Minayo (2000, p. 17), "it is research that feeds the activity of the world and the updating of the reality of the world", he also mentions that the methodology of research is the path of thought and the experience of reality, considering research as:

> [...]basic activity of the sciences in their inquiry and discovery of reality. It is an attitude and a theoretical practice of constant search that defines an intrinsically inoculated and permanent process. It is an activity of successive approximation of reality that is never exhausted by making a particular combination between theory and data. Theory is constructed to explain or understand a phenomenon, a process, or a set of phenomena and processes. This set of theories constitutes the empirical domain of theory, as it always has an abstract character (Minayo, 200, p.18).

In order to fulfill the objective of the research, this study implied an exploratory research, making a qualitative approach, as it tries to know and understand the contributions of the social worker in hospital humanization, as well as the limits and challenge of this professional in the hospital environment. For Kipnis (2005, p. 62), the central interest of qualitative research is "to understand how reality is constructed by subjects perceived as social actors".

The target audience of this research was the Social Workers in the health area, who work in the hospital environment in the region of Passo Fundo-RS. The research was restricted to only three hospitals in the city that have this professional. Therefore, we sought to clearly contemplate the objective of the research as much as possible. Once the research population was characterized, a time was set for the interview, which was conducted and recorded personally by the researcher.

The research was divided into stages: first, a survey was made of the hospitals in the city of Passo Fundo-RS that have the Social Worker professional, and that work with the

Revista ARACÊ
ISSN: 2358-2472

National Humanization Policy. Based on this analysis, an e-mail was sent to these institutions, inviting them to participate in the present study. Subsequently, the date and time for the interview was set, which was semi-structured, and recorded on different dates with the three invited professionals. Next, the analysis of the data obtained and their transcriptions was carried out, where the interviews were read and re-read. Finally, as a last step, the analysis and discussion of the collected data was carried out.

During the research, ethical principles were respected, ensuring the anonymity of the participants. Before starting the interview, the sample population was informed about the research and its objectives, and those who wished to participate in it received the Informed Consent Form (ICF) to sign, agreeing to it.

RESULTS

Based on the objective of the research, the view of the Social Worker in hospital humanization, the presentation of the results obtained were organized in order to verify the proposed objectives, making a comparison with the answers given by the three participating professionals, because due to the lack of insertion of this professional in the scope of health, and hospital humanization, the research was restricted to only three institutions and three Social Worker professionals who were willing to answer the research questions.

Due to this theme being recent and still little discussed in the profession, the interviewees decided not to identify themselves and not to identify the Institution in which they work. For these reasons, they were treated here as interviewees 1, 2 and 3. The Social Worker professional has increasingly been inserted in health units and services, especially in hospitals, to implement and ensure the effectiveness of the National Humanization Policy together with professionals from other health-related areas.

It is also understood as necessary to expose the understanding of the actions that are understood as humanizing, these should be thought of from the perspective of valuing the different subjects involved in the health production process (users, workers and managers); fostering the autonomy and protagonism of these subjects; increased degree of co-responsibility in the production of health and subjects; establishment of solidarity bonds and collective participation in the management process; identification of health needs; change in the models of care and management of work processes, focusing on the needs of citizens and the production of health; commitment to the environment, improvement of working conditions and service (Brasil, 2004, p.6).

Revista ARACÊ
ISSN: 2358-2472

In view of the above, for interviewee 1, the implementation of the National Humanization Policy requires the participation of all subjects involved in the process, from health workers, managers and users. Currently, there is an attempt to create harmony and alignment between the subjects and the processes involved, always seeking to consider the current care model, its demands, transformations and consequences resulting from technological and scientific advances in transition in the health area, in order to better manage its effectiveness.

In the same sense, for interviewee 2, "the task of humanization challenges us to reflect on the way of being and acting with others and with the world". In the area of health, this reflection seems to be justified in view of the perception of the fragmentation of human relations, aggravated by the growth of phenomena that come to value technique and scientific advances, dissociated from respect for human dignity, from the violation of human rights, which are essential to qualified health care.

For interviewee 3, "humanization as a policy should motivate environments that promote the construction and exchange of knowledge, investing in teamwork modes", thus placing itself as: "inference strategy in the health production process taking into account the subjects, who, when mobilized, become capable of transforming realities by transforming themselves in this process" (Benevides, cited by Junges, 2010, p.9).

In the humanization process, according to the Parameters for the Performance of Social Workers in Health, it becomes relevant for the social worker to develop the following articulation actions with the health team: a) To build and implement, together with the health team, proposals for training and qualification of technical-administrative personnel with a view to qualifying the administrative actions that have an interface with user care (...); b) To encourage and participate in the discussion of the care model and the elaboration of standards, routines, and service offers of the unit, based on the interests and demands of the user population; c) Participate in the unit's humanization project in its expanded conception, being transversal to all the unit's care and not restricted to the entrance door, having the health reform project as a parameter (Social, 2009, p. 31-32). In this sense, for interviewee 1:

> "The social worker, together with the multidisciplinary team, seeks to develop a process of reflection that leads the team to understand the meaning and meanings of humanization, in order to avoid misunderstandings that result in fragmented, isolated and punctual actions (E1)."

Revista ARACÊ
ISSN: 2358-2472

In the understanding of interviewee 2:

> "Humanization is understood from a broader perspective that enables professionals to analyze the social determinants in the health-disease process, as well as working conditions and health care and management models (E2)."

Through this, space should be opened for the protagonism of health service users, in the sense of listening to them, but also that they can evaluate the services and care provided, in order to identify their reach and effectiveness. Finally, it is necessary to seek from the participation of users and health workers, the review of the project of the health units, as well as the service routines in a greater perspective of rethinking the work processes and breaking with the health care model centered on the disease. Also, according to interviewee 3:

> "The social worker, as a member of a health work team based on the expanded concept of health, is the professional who identifies the social needs of users as well as the social conditions in which they are inserted in a perspective of totality, thus being able to contribute to the team in order to make the humanization process more effective (E3)."

Regarding the process of humanizing actions, interviewee 1 observes that:

> "The process of humanizing actions in the hospital environment in which it is inserted has implied a major change in management models, which are actually not only concerned in the general context with the true meaning of the word "humanization", but as a whole the institution needs to adapt to the new norms and rules to ensure the process of seeking accreditation (E1)."

According to the National Accreditation Organization (ONA), Accreditation is defined as a system of evaluation and certification of the quality of health services. In the understanding of interviewee 2:

> "The humanizing actions carried out in the institution in which he is inserted, also aim at the search for accreditation, but it is inserted in a plastered management, since the actions are being planned at first by the managers of the various sectors existing in the hospital environment, which in the view of the interviewee should be carried out by a participatory management, among managers, workers and users, to better achieve the objective of humanization (E2)."

For interviewee 3, the humanizing actions carried out by the institution he represents are still challenging, as changes and innovations were proposed by the management in search of hospital humanization, but the institution is going through a process with great limitations, which greatly hinders these changes, but that the managers are looking for ways

Revista ARACÊ
ISSN: 2358-2472

to continue this process, which generates many costs in terms of training, adaptations of environments, research, among others. With regard to continuing education, interviewee 1 says that:

> "A hospital can be very well provided and served by technological and scientific advances, however, with regard to care it can be inhumane to the extent that it reduces the person to an object, to a pathology, so we need to make workers understand the importance of continuing education, to always be evaluating their care, seeking a look of totality with solid bases to better act, and nothing better than improvement for this (E1)."

Hospital humanization requires the protagonism of all subjects involved in this process, which requires a change in management models, humanization is based on a participatory management model, but for interviewee 1, "the participation of workers and users in health is still very small, which can be attributed by the form of management applied". With regard to continuing education, interviewee 1 says that:

> "A hospital can be very well provided and served by technological and scientific advances, however, with regard to care, it can be inhumane to the extent that it reduces the person to an object, to a pathology, so we need to make workers understand the importance of continuing education, to always be evaluating their care, seeking a look of totality with solid bases to better act, and nothing better than improvement for this (E1)."

In the view of interviewee 2:

> "In the hospital environment, the professional is faced with difficult, delicate and very complex situations that demand knowledge and technical and scientific skills, demonstrating how much continuing education needs to be present in the lives of these professionals, because any type of change requires improvement (E2)."

For interviewee 3, "continuing education provides a reflective practice on the work processes and their purposes in the face of the reality experienced in the hospital environment". To conclude, it is possible to reflect on the theoretical-methodological dimension based on the contributions made by the interviewees, who believe that the methodological theory is beyond a set of methodologies and procedures, it implies a way of interpreting and reading reality in its totality, which allows us to carry out the search for knowledge to overcome the obstacles of the hospital reality encountered.

CONCLUSION

Humanization is centered in the hospital field, as it is believed that it is a privileged field of intervention, where interpersonal relationships are recommended, through which it is

Revista ARACÊ
ISSN: 2358-2472

believed that it is possible to rescue the value of communication in work processes, as well as teamwork, and has as its central axis the humanization of user care, the humanization of health professionals, and also the needs of the hospital institution.

The research aimed to analyze hospital humanization from the perspective of the Social Worker, focusing on the hospitals in the city of Passo Fundo-RS, and the professionals working in the area of Social Work within the health institutions. This study broadened the understanding of humanization, leading to the perception of it as an important space of action, considered essential for a qualified performance in the construction of knowledge and humanizing practices, allowing reflections on the understanding of humanization and how its actions are configured, generating questions about the professional practice itself.

The research carried out was qualitative, and identified some questions for reflection and possible contributions of the social worker in the humanization process. This understanding points to the importance of social workers and other health professionals to improve their capacities both in the field of creativity and in the propositional field, thus contributing to the creation of humanizing actions focused on quality and effective responsibility in the service provided. Thus, the importance of monitoring and evaluating humanizing actions was perceived, strengthening spaces for exchange and construction of knowledge in different areas of health.

It is important to emphasize that humanization in hospital care is a complex issue, which despite gaining space in the hospital environment, still encounters difficulties in its implementation process, due to centralization in management. In the research process, difficulties were evidenced, ranging from accessing health institutions in the city of Passo Fundo-RS inserted in the humanization process, to finding professionals from other areas not related to management, such as the professional social worker who was the focus of this research.

Through the difficulties encountered, it is possible to highlight the importance of decentralization of humanization processes, aiming at participatory management, as this process is very broad and complex, and its focus is directly linked to the provision of services to users, which is not carried out by the managers of the institutions, but by the different professionals who work in the hospital environment, starting with the receptionists themselves, technicians, nurses, social workers, psychologists, nutritionists, doctors, among others who have direct contact with patients and their families.

Revista ARACÊ
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