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Humanization and volunteering: a qualitative study in public hospitals

ABSTRACT

OBJECTIVE: To analyze the profile of volunteers and their work process in hospital humanization.

METHODOLOGICAL PROCEDURES: The following instruments were used: a sociodemographic questionnaire and a semi-structured interview, applied to 26 volunteer coordinators and 26 volunteers, who belong to 25 hospitals in the metropolitan area of São Paulo, Southeastern Brazil, between 2008 and 2009. Interviews were analyzed according to thematic analysis principles.

ANALYSIS OF RESULTS: Five main themes were identified: volunteer profile (age, sex, level of income); volunteer work organization (volunteer agreement, training); volunteer-hospital relationship (relationship with hospital management and employees); motivation (solidarity, previous experience with family members' or one's own diseases, personal satisfaction, conflict resolution) and benefits (individual, dual, collective); and humanization and volunteer activities (patient care, logistic support, emotional support, development of patients' abilities, leisure, organization of commemorative events).

CONCLUSIONS: In the activity developed by volunteers, there are positive aspects (such as the contribution to hospital humanization) and negative aspects (such as volunteers performing activities assigned to employees). Attention should be paid to the regulation of volunteer activities, especially patient care, and actions that value volunteer work in hospitals and volunteer integration into humanization work groups.

DESCRIPTORS: Voluntary Workers. Health Personnel. Hospitals, Public, manpower. Humanization of Assistance. Qualitative Research.

INTRODUCTION

In 2000, the Brazilian Ministry of Health launched the National Program to Humanize Hospital Care (PNHAH),^a aiming to change the predominance of scientific-technological aspects over humanistic-interracial aspects in health culture. The objectives of the PNHAH include strengthening and integrating initiatives of humanization already present, improving the quality and efficiency of care given to users and qualifying hospital professionals for a health care concept that values human life and citizenship.

In 2003, the PNHAH was replaced by the National Humanization Policy (PNH).^b The term "policy" was intentionally used instead of "program" to call attention to

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Received: 6/3/2009
Approved: 4/12/2010

Article available from: www.scielo.br/rsp

^a Ministério da Saúde. Secretaria de Assistência à Saúde. Programa Nacional de Humanização da Assistência Hospitalar. Brasília; 2001.

^b Ministério da Saúde. Secretaria Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: Política Nacional de Humanização. Brasília; 2003.

the fact that humanization should cross different actions and management levels, translating its principles into the ways different network personnel and equipment work. For the PNH, humanizing health care and management entails the following: access with welcoming, comprehensive health care, responsibility and bond, appreciation of workers and users, management democratization, and participatory social control.

The process of humanization is broad, slow and complex. In addition, there is resistance to it, as it involves changes in behavior, which, in its turn, cause insecurity. New patterns are not ready in decrees and in books;¹² therefore, the gradual building of possible approaches¹⁵ to this project requires wisdom.

One of the mechanisms created by the PNH and maintained by the PNH to develop the process of hospital humanization was the humanization group. One of its objectives is to involve the many participants of each institution with the changes of hospital institutional culture, making it more humanized. It is known that volunteers play an important role in the hospital humanization process, although few details about such participation are known.

The volunteer activity is defined as “unpaid activity performed by an individual for any type of public organization or non-profit private institution, with objectives that have a civic, cultural, educational, scientific, recreational or social work nature, including mutual aid.”^c

In 2001, the United Nations (UN), by establishing the International Year of Volunteers, extended the discussion on this theme, valuing civil society’s space of participation in countless social problems encountered by many nations. This initiative promoted the development of studies on volunteering. Themes such as the motivation to perform volunteer activities,¹ the relationship between volunteering and the volunteer’s physical and mental well-being,^{6,16,20} volunteers’ psychological, occupational, and socio-demographic characteristics^{5,20} and volunteer group management strategies^{3,4,14} have been debated in the international literature.

In Brazil, the scientific literature about volunteering^{8,9,13,17-19} points out the importance of considering this theme in a broad perspective, avoiding negative or positive unanimities^d and analyzing favorable and unfavorable aspects of the volunteer activity.

The contributions of bioethics have enriched the perspective of analysis of this theme.¹⁷⁻¹⁹ Selli & Garrafa,¹⁷ based on bioethical principles and those involving the belief in the potential of volunteers, propose critical solidarity and organic volunteering as mechanisms of intervention and transformation of society. Critical solidarity means the ability to discern the social and political dimensions present in an action of solidarity. Organic volunteering^{17,19} would be the one motivated by the exercise of critical solidarity.

Research in the field of health psychology^{8,9} has been dedicated to the following: the identification of the volunteer’s profile, their self-perception, and the health professional’s perception of volunteers; the motivations for cooperative behavior; and the stress and burnout associated with volunteering.

It is known that volunteers play an important role in hospital humanization. A study performed in public hospitals of the state of São Paulo¹⁰ showed that volunteers were responsible for 11% of humanization actions. Nevertheless, their inclusion and daily activities provided to Brazilian health services are not quite clear yet.^e

The present study aimed to analyze the profile of volunteers and their work process in hospital humanization.

METHODOLOGICAL PROCEDURES

A qualitative study was performed, aiming to understand the senses and meanings given to the set of perceptions, feelings and experiences involved with the volunteer work of 26 volunteer coordinators and 26 volunteers of 25 state hospitals in the metropolitan area of São Paulo, Southeastern Brazil, in 2008 and 2009. The volunteers were invited to participate in the study based on their coordinators’ recommendation.

The 52 semi-structured interviews (26 coordinators and 26 volunteers)^f were developed from a basic interview guide, which addressed themes related to the experience of being a volunteer (and/or a coordinator) and aspects of the activity developed in hospitals, especially those associated with the process of hospital humanization. There was flexibility as to the use of this guide; therefore, the direction of the interview also depended on the interviewee’s participation.¹¹ Before each interview, an occupational-socio-demographic questionnaire was

^c Brasil. Lei nº 9.608, de 18 de fevereiro de 1998. Dispõe sobre o serviço voluntário e dá outras providências. *Diário Oficial Uniao*. 19 fev 1998;Seção1:10.

^d Teodósio ASS. Mitos do voluntariado no Brasil: para além de boas intenções. *Rev Integração*. 2004 [cited 2010 Jul 28];7(38). Available from: <http://integracao.fgvsp.br/ano7/05/administrando.htm>

^e Moniz ALF. Atuação voluntária nas áreas de oncologia e HIV/AIDS e a percepção dos profissionais da equipe de saúde [master’s dissertation]. Instituto de Psicologia da UnB; 2002.

^f Due to the presence of two large groups of volunteers at one institution, two visits were made and four interviews were conducted (two coordinators and two volunteers).

applied. Volunteer coordinators also answered questions about the volunteer group coordinated by them.

Interviews were recorded, transcribed and subsequently analyzed, according to thematic analysis principles.⁷ Data from the occupational-socio-demographic questionnaire were analyzed in terms of frequency with the SPSS software.

The study was performed according to the guidelines and regulations for research on human beings found in Resolution 196/1996, according to the *Conselho Nacional de Saúde* (Brazilian Health Council). The project was approved by the Research Ethics Committee of the Instituto de Saúde da Secretaria de Estado da Saúde de São Paulo (State of São Paulo Department of Health, Institute of Health.), on September 17th, 2007 (Process 009/07).

ANALYSIS OF RESULTS AND DISCUSSION

A total of two groups were considered to analyze the interviews: one with the coordinators and another with the volunteers. Combined analysis was made for themes that were common to both groups.⁸ Themes were as follows: a) volunteer profile; b) volunteer work organization; c) volunteer-hospital relationships; d) motivation and benefits and e) humanization and volunteer activities.

A. Volunteer profile

With regard to age, 71% of volunteers of the hospitals surveyed (1,243 volunteers) were over 45 years of age (24% were over 66 years; 24% from 56 to 65 years; and 23% from 46 to 55 years). Volunteer coordinators highlight life experience and maturity as positive elements for the role of a volunteer, due to the fact that elderly individuals tend to reestablish their goals and priorities, giving more importance to emotionally significant experiences, rather than material and financial achievements.^{5,20}

“The elderly volunteer has more tranquility. He’s calmer; he’s done what he had to do.” (C4)

Of all volunteers, 89% were women. The larger proportion of women could be associated with their retirement laws, as their required number of years of work is nearly 15% lower than that of men, and their life expectancy, 10% higher.¹⁷ For those women who did not previously work out of their homes, the choice for volunteer work may be attributed to their search for a meaningful activity, after their children have reached adulthood.⁵ Another reason could be related to the hospital demands for soft services, which focus on the

comfort and emotional well-being of patients and the reduction in patient’s and family’s anxiety;⁹ i.e., care activities, traditionally associated with women.

Suddenly, her children graduate and leave home (...) then she wants to give more of herself (...) she wants to give that emotional support (...) and this is probably a way for her to support herself.” (C17)

Among the interviewed volunteers, there was a great variability in income (14% earned from one to two minimum wages; 26%, from three to five; 23%, from six to ten; 23%, from 11 to 20; and 14%, more than 20) and profession (housewives, welders, secretaries, teachers, biologists, school principals and others). These data indicate that the volunteer activity is not a prerogative of individuals with a higher socioeconomic status anymore,^{2,4} and that there is a broad scope of possible motivations for volunteering.¹ Additionally, the fact that 66% of the interviewed volunteers take part in paid activities suggests a change in the traditionally described profile, according to which volunteers would consider volunteering as a way to be busy.

Having a certain religious belief seems to be a constant in volunteering.¹ According to data from the socio-demographic questionnaire, all coordinators and volunteers interviewed reported they had a religion.

B. Volunteer work organization

One of the instruments used to manage volunteering is the volunteer agreement, through which:

“...he [the volunteer] knows he doesn’t have an employment contract and that his job is not paid. He has to wear a white coat and an identification badge and he has to follow the hospital’s biosecurity norms.” (C16)

The training course was usually held during three months; this period of time also serves as experience, at the end of which it would be defined whether the volunteer continued their work in the hospital or not.

In the majority of hospitals, although volunteer activities may complement health professionals’ tasks, they cannot replace them, once they require specialized skills.⁴

“[The volunteer] is not allowed to perform any technical procedures, like, checking if the IV is flowing well, if there is a clogged tube (...) or any technical touch on the patient.” (C12)

Although many hospitals recommend that volunteers do not impose their religious beliefs and values, some coordinators have reported such situation, which is usually difficult to handle.

⁸ The content in parentheses corresponds to coordinator (C), volunteer (V) and number of the hospital. Thus, the initials C4 mean coordinator of hospital 4.

“You can’t persuade the patient to follow your own religion. Because, sometimes, many volunteers want to work here to convert others (...) to that religion they think is the right one.” (C13)

With regard to the number of hours dedicated to volunteer work, a high number of hours of work was found both in the group of coordinators (32% working from 21 to 40 weekly hours, and 12%, over 40 weekly hours) and in the volunteer group (11%, from 21 to 50 weekly hours, and 9%, over 50 weekly hours). This can compromise the well-being provided by the volunteer activity^{16,20} and lead to stress and burnout symptoms as well, because the hospital activity involves being in contact with disease and suffering.⁹ On the other hand, the tendency of spending many hours away from home may be an indicator of difficulties with spouses or family.

“We had a very dedicated volunteer (...) She spent all day in the hospital... But as time went by, she got very stressed (...) and started having problems with the patients.” (C24)

C. Volunteer-hospital relationships

The relationship between the volunteer group and the hospital institution is not always harmonious. A frequent tense situation for the volunteer group involves management changes.

“When management changes, it’s very funny: the new director sees us as ladies of leisure, he thinks that we come to the hospital to pass the time (...) [a long time must pass] until we’re discovered.” (V6)

With regard to volunteer coordinators, there is no uniformity regarding their inclusion in the institution. In certain hospitals, the coordinator is an employee; in others, he/she is a volunteer; yet in others, coordination is the joint work of an employee and a volunteer. Those who are both volunteer coordinator and hospital employee (11 out of the 26 participants interviewed) tend to complain about work overload.

“My difficulty, sometimes, is that I have to give attention to them [volunteers] and, at the same time, have to fulfill our role as professionals...” (C18)

At times, employees have negative reactions to volunteering,⁴ fearing to be replaced by volunteers.

“Ill-informed employees think that volunteers will take their jobs... At first, we felt rejected by some of the employees.” (V9)

The material collected from interviews indicates the necessity for hospitals to understand the importance and potential of volunteering⁸ and to encourage volunteers to cooperate with the institution’s goals and objectives.

D. Motivation and benefits

There is no consensus among different fields of knowledge in regard to basic questions about the behavior of helping others and that of being helped.^{1,9,18} The motivation for volunteering may have many nuances.

As shown in the study by Moniz & Araujo,⁹ one type of motivation identified was one’s previous experience with a certain disease (one’s own or a close person’s).

“In life, you learn through love or through pain. In my case, it [being a volunteer] really was through pain and the need to find somebody, because when I needed, I couldn’t find any. The idea is that other people don’t have to go through what I did...” (V2)

The search for personal fulfillment^{1,9,18} was also pointed out as motivation for volunteering: giving meaning to one’s life, developing potential abilities, feeling useful and increasing the circle of social contacts were reasons given by volunteers.

“I was doing nothing at all... I needed a goal... Now, I’m useful, I know the patient is waiting for me and that I’m going to help him...” (V26)

Some coordinators reported that the volunteers are often looking for an activity to either resolve or forget about conflicts and problems,¹ which would not be an early impediment to volunteering. However, there is the need for health care measures and training, especially the volunteer coordinator’s, as a way for them to distinguish the magnitude of a problem faced by the volunteer candidate and adequately decide whether to admit this candidate or not.

With regard to the perception of volunteer work benefits, the interaction among three aspects mentioned by Selli et al is observed:¹⁸ individual (the volunteer is benefited: learning, overcoming oneself, re-dimensioning of everyday life and finding one’s own humanity); dual (the volunteer and the patient are benefited simultaneously, i.e. they provide and receive benefits, in a horizontal relationship); collective (the social dimension is present – one makes oneself useful to the needs of others). In regard to the subjects of this study, the collective aspect presents itself in a tenuous way. The great emotional availability found in interviewees is not always associated with critical solidarity,^{17,19} which is still incipient as a motivational guide for volunteer activity; thus, there is a predominance of the care dimension.⁸

Nevertheless, there is evidence of the direction being oriented towards a volunteering model committed to current specific demands.¹⁷

“I didn’t have any problems, I was well aware [of my social role] when I came” (V7)

E. Humanization and volunteer activities

Some of the terms used by volunteers highlight the close relationship perceived between volunteer activity and humanization: “being a bridge, being a link, welcoming, smoothing”.

“The volunteer provides that ‘link’ between patient and doctor, patient and nurse, patient and the family member who is waiting outside.” (C7)

One of the interviewees emphasized that volunteers can contribute and they have in fact been contributing to the transformation of hospitals before official humanization policies are implemented.

“The hospital doesn’t need to be a cold place, a place where people only talk about diseases, it can be a place of transformation (...) And this has always happened here, even before this humanization stuff.” (C15)

However, although the core of volunteer activity is closely related to hospital humanization proposals, the integration with hospital humanization groups is not the main focus; there is still a gap between this group and the volunteer group.

Volunteer activities are varied, contributing, as a whole, for hospital humanization. These activities are as follows:

- fundraising: visits to companies seeking donations, charity lunches and dinners, campaigns to raise donations;
- donations to patients: food, wheelchairs, clutches, layettes, towels, blankets, slippers, medicines, prostheses;
- donations to the hospital: rebuilding of indoor and outdoor areas, wall painting, purchase of toys for the playroom, purchase of materials for workshops, purchase of materials and equipment (bedpans, general devices);
- patient care: offering food, helping in baths and changing their position, helping with walks, making beds, helping mothers to dress their babies;
- logistic support: phone calls to patients and relatives, patient follow-up in the hospital, organization of lines, exam follow-up, transport of materials to the laboratory, transport of internal documents;
- emotional support: hospital welcoming, establishing bonds with patients, their relatives and others accompanying them;

- specific care: music therapy, yoga, hydrogymnastics, pre-delivery exercises, massages;
- aesthetics and beauty: setting up a small “beauty parlor”, haircuts, hairdos, pedicure, manicure;
- guidance and teaching: information about hospital routine (for patients and those accompanying them), guidance on breastfeeding, participation in technical guidance (in regard to specific diseases), help with school homework;
- development of patients’ abilities: handicrafts, computing, carpentry, painting;
- leisure: recreational activities in bed and in playrooms, educational games, theater;
- organization of commemorative events: celebrations related to special dates, such as Christmas, Mothers’ Day and others.

The activities previously mentioned were classified into six categories: a) typical volunteering activities (fundraising, donation to patients, donations to the hospital); b) activities related to soft services (emotional support); c) activities the hospital needs (patient care and logistic support); d) socializing activities (recreation, commemorative events); e) educational activities (guidance and teaching, development of patients’ abilities); f) special activities (special care, aesthetics and beauty).

With regard to fundraising and donation (“a” category), some interviewees mentioned the advantages of having an association to legally act on its behalf, allocating resources and making agreements. The key point is that volunteer work does not exist to replace actions that should be the government’s duty.⁸ However, due to limited government resources for the most essential public services, volunteering plays a compensatory role; there are so many demands that volunteers frequently feel responsible for the solution to problems that should not be their responsibility.¹³

With respect to activities associated with soft services (“b” category), it is relevant to inquire whether official humanization policies to improve relationships between health professionals are really being followed. Likewise, it should be questioned if the volunteers’ need to be a link between professional and patient expresses the fragmentation of care between the technical aspect and the relational aspect (soft services). In terms of welcoming actions, certain activities, already performed by volunteers for a long time, have been recently adopted in official health care programs.^{h,i}

^h Secretaria Estadual de Saúde de São Paulo. Jovens Acolhedores. São Paulo; 2003[cited 2010 Jul 28]. Available from: <http://www.jovensacolhedores.saude.sp.gov.br/>

ⁱ Secretaria Estadual de Saúde de São Paulo. Programa Conte Comigo. São Paulo; 2003[cited 2010 Jul 28]. Available from: http://www.saude.sp.gov.br/content/humanizacao_acoes_conte_comigo.mmp

Therefore, although the material of the interviews points to a poor connection between volunteers and humanization groups in many aspects, the evaluation of necessities is associated with action proposals of both volunteers and the government.

In regard to patient care and logistic support (“c” category), it is worth remembering the history of the nursing assistant profession. Until 1986, three nursing categories worked in hospitals: nurse, nursing assistant and nursing attendant. With the implementation of Law 7,498/86, the nursing attendant category became extinct. Not hiring new attendants forced institutions to change routine activities of the nursing practice: activities that were performed by nursing attendants (closely associated with hygiene and food) became the responsibility of assistants, thus overloading them. In the 1990s, there were few attendants in the health network, creating a gap in activities previously carried out by them. As a result, nowadays, activities that used to be performed by attendants are now being performed by volunteers. In several hospitals, patient food distribution and management are activities carried out by volunteers. These questions include the adequacy of this activity for volunteers, the supervision of such activity and who would take notes about the diet’s acceptance or refusal in the nursing report.

With regard to other types of care offered to patients (for instance, helping with baths and walks), it is not clear where the limit of volunteer and professional actions lies. These activities should be directly supervised, at the least.

CONCLUSIONS

The results show problematic and positive aspects of the volunteer activity in hospitals in the metropolitan area of São Paulo.

The problematic aspects are those associated with volunteers performing activities that are not their responsibility and that might pose risks to the patient, the hospital and themselves. The latter includes coordinators’ work overload and volunteers with excessive weekly hours of activities. Therefore, the existence of rules, norms and limits is essential for volunteer activities.

On the other hand, volunteering was considered very useful to the hospital and very satisfactory for volunteers. Thus, it is important to offer conditions for health institutions to manage and develop volunteer activities more efficiently. Some possibilities are as follows: promoting volunteer management courses for volunteer coordinators, providing adequate physical space for volunteer activities, and organizing specific events to improve volunteer work.

From the point of view of the volunteer’s inclusion in the hospital humanization process, there is the need for more communication with humanization groups, so that volunteers and groups can benefit each other and work for the transversality for the institutional humanization.

In regard to the evolution of groups aimed at organic volunteering, volunteer associations would be a privileged place to achieve such purpose, thus having a potential role in this process.

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The authors declare that there are no conflicts of interest.