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SPIRITUALITY/RELIGIOSITY AND HUMANIZASUS IN FAMILY HEALTH UNITS

Espiritualidade/religiosidade e o HumanizaSUS em Unidades de Saúde da Família

Espiritualidad/religiosidad y el HumanizaSUS en Unidades de Salud de la Familia

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ABSTRACT

Objective: To describe and compare the influence of spirituality/religiosity and HumanizaSUS on the clinical practice of health professionals working in Family Health Units. **Methods:** A descriptive, cross-sectional study, in which all 10 graduate health professionals of the Family Health Units of Jiquiriçá, Bahia, were interviewed. The interviews were carried out by means of a questionnaire adapted from the multicenter study SEBRAME (Spirituality and Brazilian Medical Education), in addition to a questionnaire specifically developed to approach HumanizaSUS. **Results:** Of the interviewees, 40% (n=4) said they do not have any religion but believe in God; 30% (n=3) are Evangelical/Protestant, 20% (n=2) are Catholic, and 10% (n=1) say they have no religion and do not believe in God. Most professionals (n=6; 60%) reported moderate intensity of influence of religiosity/spirituality on the clinical practice. Most (n=9; 90%) of the professionals know HumanizaSUS, and 50% (n=5) declared they apply the orientations and guidelines of the program. **Conclusion:** The spirituality/religiosity was more influential in the clinical behavior of the professionals interviewed than HumanizaSUS.

Descriptors: Humanization of Assistance; Family Health Strategy; Spirituality; User Embrace; Holistic Health.

RESUMO

Objetivo: Descrever e comparar a influência da espiritualidade/religiosidade e do HumanizaSUS na prática clínica de profissionais de saúde de Unidades de Saúde da Família. **Métodos:** Estudo descritivo e transversal, em que se entrevistaram todos os 10 profissionais de saúde de nível superior das Unidades de Saúde da Família do município de Jiquiriçá, Bahia, Brasil, no período de janeiro a julho de 2016. As entrevistas ocorreram por meio de questionário adaptado do estudo Multicêntrico SEBRAME (Spirituality and Brazilian Medical Education) e de questionário específico desenvolvido para a abordagem do HumanizaSUS. **Resultados:** Dos entrevistados, 40% (n=4) disseram que não possuem nenhuma religião, mas acreditam em Deus; 30% (n=3) são evangélicos/protestantes; 20% (n=2) são católicos e 10% (n=1) responderam não ter religião/não acreditar em Deus. A maioria dos profissionais (n=6; 60%) relatou haver intensidade moderada da influência da religiosidade/espiritualidade na prática clínica. A maior parte dos profissionais (n=9; 90%) conhecem o HumanizaSUS, e 50% (n=5) afirmaram aplicar as orientações e diretrizes do programa. **Conclusão:** A espiritualidade/religiosidade influenciou mais o comportamento clínico do profissional investigado do que o HumanizaSUS.

Descritores: Humanização da Assistência; Estratégia Saúde da Família; Espiritualidade; Acolhimento; Saúde Holística.



RESUMEN

Objetivo: Describir y comparar la influencia de la espiritualidad/religiosidad y del HumanizaSUS en la práctica clínica de profesionales sanitarios de Unidades de Salud de la Familia. **Métodos:** Estudio descriptivo y transversal en el cual se ha entrevistado a todos los 10 profesionales sanitarios de nivel superior de las Unidades de Salud de la Familia del municipio de Jiquiriçá, Bahía, Brasil, en el periodo entre enero y julio de 2016. Las entrevistas se dieron a través de un cuestionario adaptado del estudio Multicéntrico SEBRAME (Spirituality and Brazilian Medical Education) y de un cuestionario específico desarrollado para el abordaje del HumanizaSUS. **Resultados:** De entre los entrevistados, el 40% (n=4) dijeron que no tienen religión pero creen en Dios; el 30% (n=3) son evangélicos/protestantes; el 20% (n=2) son católicos y el 10% (n=1) contestaron que no tenían religión/no creen en Dios. La mayoría de los profesionales (n=6; 60%) relató una intensidad moderada de la influencia de la religiosidad/espiritualidad en la práctica clínica. La mayor parte de los profesionales (n=9; 90%) conocen el HumanizaSUS y el 50% (n=5) afirmaron que aplican las orientaciones y directrices del programa. **Conclusión:** La espiritualidad/religiosidad ha influenciado más la conducta clínica del profesional investigado que el HumanizaSUS.

Descriptor: Humanización de la Atención; Estrategia de Salud Familiar; Espiritualidad; Acogimiento; Salud Holística.

INTRODUCTION

It is in the 1988 Federal Constitution, in its article 198, that the new institutionality of health finds its foundations, from which the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*) is defined. Over the years, SUS has been improving and developing new ways to get closer to the population and better serve it, as well as to better understand the reality of the communities. Along SUS continuous improvement and advancement, in 1994, the Family Health Program (*Programa de Saúde da Família - PSF*) emerged, with a structuring perspective and focused on Primary Health Care (PHC⁽¹⁾).

In the course of SUS construction, the National Program for Humanization of Hospital Care (*Programa Nacional de Humanização da Assistência Hospitalar - PNHAH*) was created, in 2000, and, in 2003, the National Policy for Humanization of Health Care and Management in SUS was launched, which is also called the National Humanization Policy (*Política Nacional de Humanização - PNH*), or HumanizaSUS, intended to expand humanization beyond hospital settings⁽²⁾.

In response to the crisis of the medical disease-oriented model of care that still prevails in the country, the Family Health Strategy (FHS) arises, which aims to propose a more effective change in the way of thinking about health. In the FHS, the family health team is responsible for acting in the promotion, prevention, recovery and maintenance of the health of the population, producing actions that seek comprehensive health care and establishing respect and bond with the community⁽³⁾.

The FHS should be characterized according to the current PHC Policy, as it proposes that health care should be centered on the family, understood and perceived from its physical and social environment, which leads health professionals to come into contact with the life and health conditions of the population, enabling them to have a broader understanding of the health-disease process and the need for interventions that go beyond the curative practices, prevailing the establishment of bonds between the professionals and the population, so as to ensure that Primary Health Care be carried out properly⁽⁴⁾.

By guiding strategies and methods of articulating actions, knowledge and subjects, one can effectively maximize the guarantee of comprehensive, resolute and humanized care. In this perspective, the National Humanization Policy is extremely important since it is characterized by a set of principles and guidelines that are converted into actions in the various health practices and, by means of HumanizaSUS, uses tools and devices to consolidate networks, bonds and co-responsibility between users, workers and managers. In the National Humanization Policy, the following aspects can be attributed to the term humanization: valorization of the subjects participating in the health production process (users, managers and workers); promotion of autonomy, protagonism, co-responsibility in the production of health and subjects; and improvement and approximation in the professional-user relationship, with the resulting effectiveness of humanization⁽³⁾.

Humanization is necessary in each and every human relationship, serving as a channel to effectuate the holistic and sensitive care for each person. In this way, humanizing is reflected in the action of the one who provides care, who begins to be regarded as an important and dynamic presence, capable of embracing, reflecting, recognizing and performing, with sensitivity and competence, a care aimed for the needs of those who are provided with it⁽⁵⁾. The caregiver's action on the user goes beyond the health itself, and one must also consider their spiritual and/or religious dimension. Such dimension occupies a prominent place in people's lives and also shows that it is indispensable to know the spirituality of health care users when planning care⁽⁶⁾, since valuing the spiritual and religious dimension in health care positively influences people's well-being, enabling professionals to have a comprehensive view of health⁽⁷⁾.

Spirituality can be defined as an individual and subjective resource of connection with oneself, with the other, God or other deity⁽⁸⁾; a personal search to understand questions related to the end of life, its meaning, about the relations with the sacred, and which may or may not lead to the development of religious practices or formations of religious communities⁽⁹⁾. As for religiosity, it can be understood as the exercise of an organized system of beliefs and practices (religion), which involves the

presence of hierarchies, leaders/priests and dogmas to be followed; it is how much an individual believes, follows and practices that religion⁽⁸⁾.

Thus, the relationship between the health-disease process and religiosity/spirituality goes back to the medieval period, when licenses for medical practice were given by religious authorities, as well as to Greek history, when one could hear stories about gods promoting the onset of diseases⁽¹⁰⁾.

In the quest for an holistic view of man and with the “breakup” of the biomedical model, health promotion is now regarded as the new law. But the mortal body is still seen as sacred and the only source of disease and healing. In contrast, discussions about spiritual and mental conditions have never drawn so much attention as today. Prevention and treatment for such problems arise with the advent of new discoveries in Neuroscience and other areas of science, since the existence of the “transcendental” and the “divine” in the human mind can no longer be denied, especially their actions in the existence of the human being. Moreover, finding a meaning in life can also be regarded as a promotion of health via spirituality, where meaning is a future-oriented reality⁽¹¹⁾.

In this way, spirituality/religiosity has caused increasing interest among researchers and academics in the field of health, and in the general population as well. This topic has been the subject of much research and, in addition to that, literature of the recent time has been reporting its influence on the quality of life of individuals, as well as on the confrontation of diseases and the promotion of health⁽⁶⁾.

In the United States of America, a survey by the Gallup Institute found that 80% of Americans (87% for those aged over 65) considered true the phrase “I receive enough comfort and support from my religious beliefs”. 90% of patients state that the practice of religious beliefs are important ways to cope with and accept physical illnesses and, moreover, for more than 40% of the respondents, religion is the most important factor that helps them in such moments⁽¹²⁾. According to the literature, spirituality/religiosity has been recognized as a resource that can help people cope with day-to-day adversities, as well as in events related to illness processes⁽¹³⁾ and, for that reason, articulation with religious professionals is essential in the monitoring of patients, especially those who are in palliative care⁽¹⁴⁾.

It is also possible to affirm that the religiosity/spirituality of the health professional represents an aspect of extreme importance and that it should be studied, as it exerts a positive influence on the patient. Such influence can benefit the care provided and, at the same time, bring improvements to their quality of life and health⁽¹⁵⁾.

In view of the above, the present study aims to describe and compare the influence of spirituality/religiosity and HumanizaSUS on the clinical practice of health professionals working in Family Health Units.

METHODS

This is a descriptive and cross-sectional research carried out in the municipality of Jiquiriçá, Bahia, Brazil, with a population estimate of 15,106 inhabitants, of which 70.3% belong to the Roman Catholic Apostolic Church, 19.5% belong to the Evangelical religion, 4.2% belong to the Spiritist religion and 6% do not have religion⁽¹⁶⁾. The municipality has primary health care management, with a municipal hospital that performs urgency, emergency and outpatient care, and also has 03 Family Health Units (FHUs), which provide ambulatory care for the whole population⁽¹⁷⁾. These FHUs of the municipality represent the scenario of the present research.

The FHUs in Jiquiriçá comprise a total of 10 professionals with a higher education qualification, divided as 5 nurses, 3 physicians and 2 dental surgeons. The study was carried out with all the graduate health professionals who work in the FHUs, chosen with such criterion because the questionnaire has questions which require that the professionals have undergone academic training, as well as about their work in HumanizaSUS in the FHS, since the study adopted questionnaires that are specific for graduate health professionals.

As the instrument for data collection, it was adapted a questionnaire adapted from the SEBRAME (Spirituality and Brazilian Medical Education) study, coordinated by the Federal University of São Paulo (UNIFESP), Federal University of Juiz de Fora (UFJF) and the Brazilian Spiritist Medical Association⁽¹⁸⁾. This questionnaire is composed of sociodemographic data - gender, age, length of service, race/ethnicity and family income; clinical practice, the patient and the spirituality - knowledge and opinions about the relationship between spirituality and health in the clinical practice; academic training and the theme of spirituality - how the academic institutions approach the theme during the qualification and how the contents related to health and spirituality could be offered; dimension of religiosity - different aspects of the religiousness of the participant through religious affiliation and questions that are part of the Duke University Religion Index - DUREL, which was validated for Brazil; it has five questions that assess three dimensions of religiosity that are most related to health: organizational, non-organizational and intrinsic. In this questionnaire, interviewees are allowed to choose only one of the alternatives⁽¹⁹⁾.

In addition to the adapted questionnaire, it was included in the instrument for data collection the Spirituality Self-rating Scale (SSRS), translated and adapted to Brazil, which evaluates aspects of the individual's spirituality. Its items reflect how important the professional considers the issues regarding their spiritual dimension and applies them in their daily life⁽²⁰⁾.

For the questions related to HumanizaSUS, a specific questionnaire was developed, to which the participants answered in writing, composed of 5 questions addressing the professionals' knowledge of HumanizaSUS: if they had already read the HumanizaSUS instruction booklet, if they had already received training in the program, if they apply HumanizaSUS recommendations and guidelines, and what has changed with the implementation of HumanizaSUS. Each professional investigated received the questionnaire, could not consult any means that explained or talked about the program and could use one hour to fill it in, accompanied by the interviewer.

Data was collected from January to June 2016, tabulated in the software Microsoft Office Excel and later sent to the statistical program SPSS, version 21.0, for the execution of descriptive data analysis, with absolute and relative frequency distribution.

The present research was carried out in compliance with Resolution 466/12 of the National Health Council⁽²¹⁾ and is part of a project of the Bioethics Research Center of the Graduate Program in Nursing and Health of the State University of Southwestern Bahia (UESB), a research called "The Influence of Spirituality and Bioethics on Health", which has been approved by the UESB Research Ethics Committee with Approval no. 805380. The participants signed the Informed Consent Form (ICF) in order to have secrecy and anonymity guaranteed, as well as to grant the rights of use and disclosure of the content, in addition to the authorization for publication of the research results in papers, journals, and publicizing in national and international technical-scientific events.

RESULTS

Professionals aged between 23 and 71 years took part in this study, with a majority of women ($n = 7$; 70%), with predominance of self-reportedly white skin color ($n = 4$; 40%), while blacks and *pardos* (biracial individuals) were 3 (30%) each. The most prevalent family income among the respondents ranged from 4 to 7 and 8 to 12 minimum wages ($n = 4$, 40%) each. Regarding the length of service, it ranged from 2 to 29 years, with an average of 11 years.

Regarding the influence of spirituality/religiosity on the clinical practice of professionals for the understanding of the health/disease process and the professional/patient relationship, the following results were obtained, as shown in Table I.

Table I - Influence of the professionals' religiosity/spirituality on the clinical practice in the Family Health Units. Jiquiriçá, Bahia, 2016.

Intensity	n (%)
Huge influence	2 (20.0)
Moderate influence	6 (60.0)
Mild influence or no influence	2 (20.0)
Total	10 (100.0)

Legend: n = absolute number; (%) = relative number.

In regard to what best describes the religious affiliation, it was possible to obtain the following answers: 4 (40%) interviewees said they have no religion and believe in God, 3 (30%) are Evangelical/Protestant, 2 (30%) are Catholic and 1 (10%) said they have no religion and do not believe in God.

They were asked whether "their spirituality/religiosity modifies the way they care for their patients", about what they understand by spirituality and what they relate to the subject of health and spirituality, and the answers obtained are described as follows in Table II:

Table II - Spirituality according to the graduate health professionals of the Family Health Units. Jiquiriçá, Bahia, 2016.

Variable	n (%)
What do you mean by spirituality?	
Search for sense and meaning for human life	8 (80.0)
Belief and relationship with God/religiosity	6 (60.0)
Belief in something that transcends the matter	1 (10.0)
Belief in the existence of the soul and in an afterlife	4 (40.0)
You relate the subject "Health and spirituality" with:	
Humanization of medicine	3 (30.0)
Quality of life	5 (50.0)
Positive or negative interference of religiosity in health	5 (50.0)
Approach to living and dying.	1 (10.0)
Does your spirituality/religiosity change the way you care for your patients?	
Yes	7 (70.0)
No	3 (30.0)

Legend: n = absolute number; (%) = relative number.

When asked whether they “know the HumanizaSUS program”, or “have read the HumanizaSUS instruction booklet”, “have already received training in HumanizaSUS” and “apply the recommendations and guidelines prescribed by HumanizaSUS in their care”, the answers were the following, as shown in Table III:

Table III - HumanizaSUS according to the graduate health professionals of the Family Health Unit. Jiquiriçá, Bahia, 2016.

Variable	n (%)
Do you know the HumanizaSUS program?	
Yes	9 (90.0)
No	1 (10.0)
Total	10 (100)
Have you read the HumanizaSUS instruction booklet?	
Yes	7 (70.0)
No	3 (30.0)
Total	10 (100.0)
Have you ever received training in HumanizaSUS?	
Yes	0 (0.0)
No	10 (100.0)
Total	10 (100.0)
Do you apply the recommendations and guidelines prescribed by HumanizaSUS in your care?	
Yes	5 (50.0)
No	5 (50.0)
Total	10 (100.0)

Legend: n = absolute number; (%) = relative number.

DISCUSSION

The present study had its sample composed of physicians, dental surgeons and nurses, as these are the graduate health professionals that compose the FHS of the analyzed municipality. Nurses represented the majority and women predominated in the sample, which corroborates data from research by the Federal Council of Dentistry (CFO)⁽²³⁾ which says that 51.2% of dentists in Brazil are of the female sex, and the Federal Council of Medicine (CFM)⁽²³⁾ and the Federal Nursing Council (COFEN)⁽²⁴⁾, which point out the female sex as the majority among health professionals, especially among medical and nursing teams.

As for the clinical practice and the spirituality, most professionals in the current study reported that their religiousness/spirituality has a moderate influence on their understanding of the health-disease process and on their relationship with the patient, showing convergence with a study carried out in 2013 in the hinterlands of the State of São Paulo, with 120 undergraduate nursing students, whose perceptions were assessed, evidencing that 42.4% believed that the professional's spirituality influences the understanding of the health-disease process and the professional-patient relationship⁽²⁵⁾.

Research in the literature has sought to study the reflection of spirituality on health professional's life and relationships, proving that the professional's religiosity/spirituality can influence the relationship with their colleagues and the way they approach and interact with their patients, which may be considered essential to promote empathy between people, harmony and the balance between the dimensions of the human being, with a direct impact on the quality and the care that is provided⁽²⁶⁾.

In addition to the influence on the professional, studies show that spirituality/religiosity influences the patient's understanding of this process. A study carried out at a Basic Health Care Unit located in the State of Paraíba found benefits brought by the spirituality of hypertensive users and the importance of religious faith in the improvement of health status⁽²⁷⁾.

In another study, observing the reports made by the patients interviewed, it was possible to perceive that there is a strong connection between their faith and the recovery from the disease, even in cases when the doctors had declared them terminally ill, and they attribute such recovery to faith, which points out to the conclusion that one of the ways of coping with death and disease is associated with the strength of faith and religious beliefs, which are a means of expressing spirituality⁽²⁸⁾. Spirituality can be regarded as each person's life purpose, as well as the expression of identity, taking into account their own history, experiences and personal aspirations. When faith renders it possible that transformations take place in the patient's and the community's perception, through which the illness is understood, this allows the relief of suffering to occur gradually⁽¹⁵⁾.

Often, coping with the health-disease process goes beyond the body, including also the mind, and studies have demonstrated a greater association of spirituality and religiosity with mental health, including lower prevalence of depression, shorter time-to-remission from depression after treatment, lower prevalence of anxiety and lower suicide rate⁽¹⁴⁾. Likewise, studies demonstrate a relationship between spirituality and a better quality of life and greater general well-being⁽²⁹⁾.

As for religious affiliation, most interviewees pointed out that they have no religion but believe in God, followed by the Evangelical/Protestant religion. This shows that one of the characteristics of religion in Brazil is the diversity of creeds and/or

plurality of beliefs, which has been increasing in recent years, according to IBGE data⁽¹⁶⁾. In the last demographic census there was a decline in religious affiliation among Catholics, at the same time as there is an increase in the number of Brazilians who have no religion⁽¹⁶⁾.

It was also possible to realize that 90% of the interviewees of the study in question believe in God and 50% attend some religion. When it comes to the religiosity dimension, the professionals were asked whether “their spirituality/religiosity modifies the way they care for their patients” and 70% of those interviewed said yes. In this way, it corroborates the literature when one understands that the spiritual dimension brings well-being, peace, tranquility, harmony, understanding and, above all, appreciation of the human being who needs care⁽²⁶⁾.

The importance of the spiritual dimension in the care and life of the patient can also be observed in another study, where it was possible to conclude that the patients, in search for relief and comfort, intensified their faith and religious practices after the diagnosis of neoplasm⁽²⁸⁾.

Likewise, it is shown in the literature that patients wish to receive this type of support, varying from 33 to 94% in international studies⁽⁹⁾ and 79 to 87% in Brazilian studies⁽³⁰⁾ depending on the type of care, place of practice and clinical context.

Care, in a broad concept, can have several meanings embedded, such as: zeal, diligence and attention that becomes real in life in society and, at the same time, care is a priority, representing an attitude of concern, responsibility and affective involvement with the other⁽³¹⁾. In this perspective of care and interpersonal relationships⁽³²⁾, spirituality offers growth in the various fields of the relationship and in the interpersonal field, motivates tolerance, unity and the sense of belonging to a group.

Regarding the clinical practice, the patient and the spirituality, when the professionals of the current research were asked about what they understood by spirituality, being allowed to mark several options, the most cited was the one that said that spirituality represents the search for sense and meaning for human life, mentioned by 80% of respondents, corroborating a study that states that the various definitions of spirituality, in general, encompass the search for meaning and purpose of life⁽¹⁵⁾. Such understanding of spirituality is of extreme importance, as it certifies what some authors say in their studies, which explain that spirituality is broader and more personal than religiosity, since it is related to a set of intimate values, inner completeness, harmony, connection with others; it stimulates an interest in others and in oneself; and a unity with life, nature, and the universe⁽¹⁵⁾.

When the professionals of the current study were asked about “health and spirituality”, the most cited assertions were quality of life and positive, or negative, influence of religiosity on health, both cited by 50% of respondents. This data is confirmed by the assertion that spirituality and religiosity have been recognized as helpful resources in coping with adversities and traumatic events of daily life, such as in cases of illness and hospitalization⁽³³⁾. Moreover, one can consider the World Health Organization’s recognition of spirituality⁽³⁴⁾ as a component of the concept of quality of life, being associated with better physical and mental health, making it possible to perceive such positive interference. This is also in agreement with a demonstration of the relations between greater spirituality/religiosity and better mental health, clinical outcomes, general well-being and quality of life, and longer survival, that is, it corroborates the answers of the professionals interviewed in this research⁽¹⁰⁾.

When interviewees of the current survey were questioned about HumanizaSUS, it was possible to see that 90% knew the program, but none of them had received training in the program. From the results obtained about HumanizaSUS, one can observe that there is a large difference in the percentage between those who know the program and those who apply the guidelines, making it possible to observe that knowing the program and reading about it is not enough for it to be practiced. It is necessary to consider that humanization aims to overcome the biomedical model, focusing on the user as the protagonist of the care process⁽³⁵⁾. At the same time, humanization is a broad, time-consuming and complex process, which faces resistance, since it involves changes in behavior and a rupture with each individual’s formative process, questions that always arouse insecurity⁽³⁶⁾.

Furthermore, lack of training can be a major contributor to the poor practice of the program, since the program has its own instruction booklet that should be passed on to the professionals, and the insertion of the program must be accompanied by training and courses that enable the professional to know it and, consequently, apply it in the clinical practice⁽¹⁾.

The fragility in training and in the policies of insertion of this program in the PHC is evident, despite the definition, in the HumanizaSUS Instruction Booklet, of the following strategies for implementing the program: within the SUS institutions, it is proposed that the National Humanization Policy be part of the state and municipal government plans, as it is already comprised in the National Health Plan and in the Commitment Terms of the Pact for Health. In the axis of permanent health education, it is indicated that the National Humanization Policy be included as subject and/or curricular components of undergraduate and graduate programs and extension courses in health, being linked to the educational institutions, guiding the processes of permanent education of health workers at the very health services. In the information/communication axis, the inclusion of the National Humanization Policy in the health debate is proposed by means of media action and broad social discourse. Humanization depends on the health professional’s ability to speak and listen, to dialogue with their neighbor, because, without communication, there is no humanization⁽²⁾.

It should be understood that communication is a process of understanding and sharing messages sent and received, in which the messages and the way in which they are exchanged influence people’s behavior⁽³⁷⁾. This makes it possible to compare

the influence of spirituality/religiosity and/or HumanizaSUS on the clinical behavior of these professionals, from which comes the greatest influence, since, in contrast to HumanizaSUS, spirituality/religiosity influenced the clinical care provided by 70% of the respondents in the study in question.

The present study presented a limitation regarding the size of the sample. Despite representing 100% of the population of the assessed municipality, it is of reduced size, allowing to consider the findings only for the study population. The next steps, in the short and medium term, would be carrying out further studies at local and regional level, with larger samples, making it possible to broaden the results to more extensive levels.

CONCLUSION

It was possible to conclude that there is influence of spirituality/religiosity on the clinical behavior of the investigated professionals, regardless of the belief in God or religious affiliation. As for HumanizaSUS, there is a large difference in percentage between those who know the program and those who apply their guidelines, making it possible to observe that knowing the program and reading about it is not enough for it to be practiced, indicating that the lack of training can contribute to the poor practice of the program.

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