Very brief historical considerations about the process of vaccination of children and adolescents against COVID-19 in Brazil

Brevíssimas considerações históricas sobre o processo de vacinação de crianças e adolescentes contra a COVID-19 no Brasil

Breves consideraciones históricas sobre el proceso de vacunación de niños y adolescentes contra la COVID-19 en Brasil

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According to the World Health Organization (WHO), overweight and obesity can be defined as the abnormal or excessive accumulation of fat, which can be harmful to health.[1] These public health problems have acquired pandemic proportions, where approximately, 4 million people die each year as a result of or from complications related to.[1,2]

In this way and, according to estimates, obesity since 1975 around the world has almost tripled and, in 2016, more than 1.9 billion adults who were 18 years of age or older were overweight and of these, more than 650 million were obese.[2] Obesity has a high prevalence in Europe and the United States (USA), generating an incidence greater than 40%.[3,4]

Currently, obesity and Covid-19 are considered global pandemics, and for some researchers, obesity can strongly aggravate the impacts on people affected by this viral disease. Covid-19, who have a high body mass index (BMI), are at greater risk than those who are not serious.[3,4]

Obese patients who develop Covid-19 and who have a high BMI have a greater need for treatment in an Intensive Care Unit (ICU) and the use of mechanical ventilation (MV), as a form of support for those who are unable to develop respiratory incursions of spontaneously.[5,6] In addition to obesity, metabolic syndrome (MS) can cause damage to various organs of the body, stimulating their irregular functioning, when faced with a high degree of stress in which the patient finds himself, during the your treatment.[5,6,7]

Aiming to provide greater technical and scientific quality to the process in question, as well as to contribute to the strengthening of national public health, on December 3, 2021, ANVISA gathered a group of experts whose goal was to deal with vaccines to be available for application and immunization with children of the Brazilian nation.[4,5,6]

EDITORIAL

Interested in continuing the process initiated with ANVISA, PFIZER on 12/06/2021 responded to the proposed technical requirements, and on 12/10 /2021 An important meeting was held with representatives of various societies and medical associations with the requesting multinational pharmaceutical company.[4,5,6]

In a large and enlightening document, signed by three (03) important entities of health professionals, namely the Brazilian Society of Immunology (SBIm), the Brazilian Society of Infectious Diseases (SBI) and the Brazilian Society of Pediatrics (SBP), presented their position on the vaccination process with the immunobiological "Pfizer/BioNTech", to be developed among children aged between 5 and 11 years, presenting themselves as favorable to its accomplishment.[7,8] It is important to clarify although, in this document, based on what is published in the international scientific literature, the existence of researches that were currently in phase 1/2 and also in 3 were exposed, being the same implemented with children belonging to this age group.[7 ,8]

These researches have shown that, after the application of two (02) doses of the "Comirnaty" vaccine, in a presentation with 10 µg (that is, 1/3 of the presentation used in adolescents and adults), children who had between 5 -11 years, developed an antibody response, characterized as neutralizing at concentrations similar to those observed in adolescents and adults aged 16 to 25 years, thus verifying the fulfillment of the previously proposed criteria for demonstrating non-inferiority.[7,8] Another issue of fundamental importance presented in this document is related to the orientation that this immunobiological should not be administered to children who are immunocompromised, and the expansion of its use is also indicated, making it part of the National Plan of Operationalization of Vaccination against COVID-19 (PNO).[7,8]

In this context, ANVISA on 12/16/2021 authorized the availability of the vaccine produced by Pfizer for children aged 5 to 11 years, signaling to the MS its position on this national public health issue.[4,5,6] Another important A noteworthy fact, as a way of better understanding this historical process of making the vaccination process available for children aged between 5 and 11 years old in Brazil, was the "Public Consultation" organized and carried out by the MS, aiming to better clarify the population about this issue. important action in public health.[9]

It was organized and implemented by the Extraordinary Secretariat to Combat COVID-19 (SECOVID) of the MS, and it is open for access by the whole of society, during the period from 12/23/2021 to 01/02/2022.[9] The importance of the aforementioned "Public Consultation" was to better inform, in addition to knowing the existing doubts of the Brazilian population, about the process of vaccination of children aged between 5 and 11 years, in order to obtain greater subsidies to society for the best and better decision-making process.[9]

Aiming to further strengthen the process of immunization and vaccination of children in Brazil, the MS on 01/27/2022 included "Coronavac" in the vaccination campaign against COVID-19 for the age group from 6 to 17 years.[4,5,6,7] Another important action developed by the MS in the child vaccination process in Brazil was the organization of "Public Hearings", on their inclusion in this immunization campaign, which was held on 01/4/2019. 2022, being headquartered at the Pan American Health Organization (PAHO), in the city of Brasília, in the Federal District (DF).[10] These public hearings were

broadcast live and on national network by Empresa Brasil de Comunicação (EBC), and society could freely participate in this process, through a channel of questions made available, aiming at greater adherence, democratization and social participation in this important activity.[10]

Below, Table 1 presents a table containing the main differences between the adsorbed inactivated COVID-19 Coronavac vaccine from Instituto Butantan for pediatric and adult use and Comirnaty Wyeth/Pfizer for pediatric use only. In this table, the characteristics of the two vaccines are presented, such as the color of the bottle cap, the age range for which the vaccine is indicated, the dose, the preparation, the route of administration and the way of use, the vaccination schedule. , dose interval, storage conditions and contraindications.

Table 1 – Differences between the Coronavac and Pfizer vaccine against COVID-19:*,**,***

	COVID-19 adsorbed vaccine (inactivated) Coronavac Butantan - PEDIATRIC and ADULT USE	**Comirnaty vaccine Wyeth/Pfizer - PEDIATRIC USE**
Bottle cap	Gray	Orange
approved age group	6-17 years old	5-11 years old
Dose	0.5 mL per dose (600 SU)	0.2 mL per dose (10 mcg)
Preparation	* Shake the vial before use. * Do not shake	* **Thawing**: If the multidose vial is stored frozen, it must be thawed before use. Frozen vials should be transferred to an environment between 2°C and 8°C to thaw. Make sure the vials are completely thawed before using. * Unopened vials can be stored for up to 10 weeks at 2°C to 8°C. *Alternatively, individual frozen vials can be thawed for 30 minutes at temperatures up to 30°C for immediate use. * Allow the thawed vial to reach room temperature and gently invert it 10 times before dilution. **Do not shake**. *Prior to dilution, the thawed dispersion may contain white to off-white amorphous and opaque particles. *** Dilute**: Thawed vaccine should be diluted in its original vial with 1.3 mL of sodium chloride 9 mg/mL (0.9%) solution for injection using a 21 gauge or narrower needle and aseptic technique. *Equalize the vial pressure before removing the needle from the vial's rubber stopper, drawing 1.3 mL of air into the empty dilution syringe. * Gently invert the diluted dispersion 10 times. **Do not shake**. * The diluted vaccine should appear as a whitish dispersion, with no visible particles. Discard the diluted vaccine if particulate matter or discoloration is observed. * **After dilution**: Do not freeze or shake the diluted dispersion. If refrigerated, allow the diluted dispersion to reach room temperature before use. * Using aseptic technique, clean the bottle stopper with a single-use antiseptic swab.

		* Withdraw 0.2 mL of Comirnaty® for children between 5 and 11 years of age. Low dead volume syringes and/or needles should be used to extract 10 doses from a single vial. The low dead volume syringe and needle combination must have a dead volume of not more than 35 microliters. * If standard syringes and needles are used, there may not be enough volume to extract ten doses from a single vial. * Each dose must contain 0.2 mL of vaccine. * If the amount of vaccine remaining in the vial cannot provide a full 0.2 mL dose, discard the vial and any excess volume.
Route of administration and method of use	* V intramuscularly, in the upper arm.	* Intramuscularly, in the upper arm.
vaccination schedule	* 2 separate doses of 0.5 mL each.	* 2 separate doses of 0.2 mL each.
Interval between doses	* 4 weeks.	* 21 days (3 weeks).
Storage conditions	* Under refrigeration (2 to 8ºC). * Do not freeze. * Protect from light. * Shelf-life: 12 months.	* Refrigerated (2°C and 8°C) for a single period of up to 10 weeks, not exceeding the original expiration date (EXP). *Alternatively, the vaccine can be stored in a freezer at -90°C to -60°C. The expiry date for storage between -90°C and -60°C is printed on the vial and cartridge after "EXP". * When stored frozen at -90°C to -60°C, the vaccine can also be thawed at 2°C to 8°C or at room temperature (up to 30°C). * Once thawed, the vaccine cannot be refrozen. * Protect from light.
* **Contraindications**	* Allergy to any of the components of this vaccine. * Patients with fever, acute illness and acute onset* of chronic illness. * Do not apply to immunocompromised children.	* It should not be administered to individuals with hypersensitivity to the active ingredient or to any of the excipients of the vaccine.

* **Source:** ANVISA, 2021.
** The authors are faithful to the source consulted.
*** As a result of several factors, changes may occur in terms of issues related to immunobiologicals presented here.

Still in relation to the vaccine, Pfizer/BioNTech, SBIm, SBP and SBI, were totally in favor of its approval, as they understand that its benefits in the population of children aged 5 to 11 years, with the immunobiological "Comirnaty", in the current context of the pandemic infectious disease of COVID-19 and its known variants, outweigh the possible risks associated with vaccination.[11] Another parameter exposed in favor of the use of this immunobiological in children in the age group in question was that, there was a demonstration of its effectiveness of approximately 90.7% (i.e., 95%CI, 67.7 to 98.3%) in relation to the prevention of COVID-19, for at least 7 days after the application of your second dose, and for a period of period of approximately 2-3 months.[11]

In this way, the emergence of serious adverse events, which had some type of association with vaccination, was not observed in the studies and research carried out, and a reactogenicity profile classified as favorable was also verified.[11] The requesting company in question also provided ANVISA with , a safety database, consisting of two (02) follow-up cohorts of children aged 5-11 years, each of which consists of approximately 1500 vaccinated children, making it possible to identify the possible adverse events.[11]

In the context of the research, it is important to highlight that the sample universe constituted can be classified as limited, that is, approximately two thousand five hundred (2,500) volunteers, who are being monitored, in addition to the follow-up time if constitute while relatively short, aiming to carry out the determination of safety over the long term.11 On the other hand, we have at present the quantity superior of five million (5,000,000) of doses already applied, of this vaccine in children who are in the age group 5-11 years with the United States of America (USA) and other nations, in relation to data classified as pharmacovigilance, not revealing the presence of adverse events of no concern.[1,2,3,11]

According to some researchers, a relationship between COVID-19 was found with regard to what is known today as Pediatric Multisystem Inflammatory Syndrome (SIM-P), and it was verified that it is of potential severity in this age group.[2,3,7, 8,11] SIM-P is constituted as a disease classified as rare, severe, in which children with COVID-19 more easily tend to develop an inflammatory process, which affects different organs of the body, conditions being more easily reported in these patients to cardiovascular disease, chronic lung disease (including asthma), immunosuppression, and obesity.[12]

Checking the issue of vaccination of children against COVID-19, it was possible to verify that, in Europe, at least twenty-three (23) nations have already approved or have already started the immunization/vaccination process in people belonging to the pediatric age group against the Covid-19, as is the case in Germany, Austria, Belgium, Croatia, Cyprus, Denmark, Slovakia, Spain, Estonia, Finland, France, Greece, Netherlands, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, Portugal, United Kingdom United Kingdom, Czech Republic and Sweden.[1,2,3] In this way, it is understood the importance of the immunization and vaccination process aimed at children and adolescents, with regard to the fight and control of COVID-19 and its variants, as a way of enhancing national public health.

The need to carry out hygiene and prophylaxis care in the fight and prevention of COVID-19 and its variants must be remembered, such as the systematic hand washing process, the use of gel alcohol, the use of masks, in addition to respect regarding the social distancing of all members of society. In this sense, we are forced to agree with the words of the Greek philosopher Aristotle (384-322 BC), when he defended in his reflections and analyzes that "through information I acquire knowledge, and knowledge allows me to act, make decisions with freedom, while others do it out of fear."

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Influence of oral hormonal contraceptives on the emergence of deep vein thrombosis

Influência do anticoncepcional hormonal oral no surgimento da trombose venosa profunda

Influencia de los anticonceptivos hormonales orales en la aparición de trombosis venosa profunda

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RESUMO

Objetivo: Descrever a ação dos anticoncepcionais orais no organismo feminino, relatando os fatores que desencadeiam a trombose venosa profunda. **Método:** Trata-se de uma revisão bibliográfica de caráter qualitativo, onde foram selecionados 11 artigos de maior relevância para compormos a pesquisa. **Resultado:** A análise dos artigos selecionados mostrou que os anticoncepcionais orais possuem ligação com a ocorrência de eventos trombóticos. Os contraceptivos são compostos por um combinado de hormônios que influenciam diretamente no surgimento da trombose venosa profunda. **Conclusão:** Os anticoncepcionais orais exercem influência no surgimento de trombose venosa profunda pois podem causar alterações no equilíbrio hemostático. Para a utilização desses medicamentos, é necessário responsabilidade e acompanhamento de um especialista, em após uma criteriosa avaliação, será selecionado o anticoncepcional mais adequado.

Descritores: Trombose Venosa Profunda; Anticoncepcional Hormonal Oral; Contraceptivos.

ABSTRACT

Objective: To describe the action of oral contraceptives in the female body, reporting the factors that trigger deep vein thrombosis. **Method:** This is a bibliographical review of a qualitative nature, where 11 articles of greatest relevance were selected to compose the research. **Results:** The analysis of the selected articles showed that oral contraceptives are linked to the occurrence of thrombotic events. Contraceptives are composed of a combination of hormones that directly influence the onset of deep vein thrombosis. **Conclusion:** Oral contraceptives influence the development of deep vein thrombosis as they can cause changes in homostatic balance. For the use of these drugs, it is necessary to be responsible and supervised by a specialist, and after a careful evaluation, the most suitable contraceptive will be selected.

Descriptors: Deep Venous Thrombosis; Oral Hormonal Contraceptive; Contraceptives.

RESUMEN

Objetivo: Describir la acción de los anticonceptivos orales en el organismo femenino, informando los factores desencadenantes de la trombosis venosa profunda. **Método:** Se trata de una revisión bibliográfica de carácter cualitativo, donde se seleccionaron 11 artículos de mayor relevancia para componer la investigación. **Resultados**: El análisis de los artículos seleccionados mostró que los anticonceptivos orales están relacionados con la aparición de eventos trombóticos. Los anticonceptivos están compuestos por una combinación de hormonas que influyen directamente en la aparición de trombosis venosa profunda. **Conclusión:** Los anticonceptivos orales influyen en el desarrollo de la trombosis venosa profunda ya que pueden provocar cambios en el equilibrio homostático. Para el uso de estos medicamentos es necesario ser responsable y supervisado por un especialista, y luego de una cuidadosa evaluación, se seleccionará el anticonceptivo más adecuado.

Descriptores: Trombosis Venosa Profunda; Anticonceptivo hormonal oral; Anticonceptivos.

REVIEW

Introduction

Oral contraceptives began to be used in Brazil in the 60s. During this period, health services were not accessible to the population, thus resulting in high fertility rates. The pills were inserted in this context, as there was a need for a way to combat the increase in the birth rate. [1]

According to a study carried out at the Johns Hopkins Bloomberg School of Public Health, it is estimated that on average 55% of married women in the world use some type of contraceptive method, and the oral contraceptive is the method that has the most supporters, due to its ease of access and ingestion.[2]

Thus, throughout life, women are exposed to large amounts of contraceptives. These drugs cause changes in the hemostatic balance, thus contributing to the emergence of deep vein thrombosis (DVT) in all users. [3]

DVT is characterized by the formation of thrombi within the dense veins, causing hemostasis in the coagulation system. The prolonged use of hormonal contraceptives composed of the main female sex hormones estrogen and progesterone are factors that can trigger this pathology.[4]

In 1961, the first record of DVT associated with the use of oral contraceptives appeared. A study carried out in 2020 at the Teaching Assistance Unit of Angiology, at the Hospital Universitário Pedro Ernesto and at the State University of Rio de Janeiro (SURJ) confirmed a two to six-fold increase in the risk of thrombosis. It is worth noting that this risk is associated with the amount of hormone that makes up the pill.[5]

As this is the most common and most accessible method among women, oral contraceptives end up being used inappropriately, without any instructions about side effects. This attitude entails greater risk to women's health, as most use the medication erroneously and without professional supervision.[6]

In this context, the question is: what influence does the oral contraceptive exert on the emergence of DVT? Therefore, the aim of this study is to describe the action of oral contraceptives in the female body, report the factors that trigger deep vein thrombosis and suggest prophylactic measures to prevent the onset of DVT associated with oral contraceptives.

Method

To carry out this research, a literature review was carried out through research of previous studies published in scientific journals, in addition to information available on the website of the Ministry of Health and the World Health Organization.

The selection of articles was made in accordance with the proposed subject and data were collected from March to August 2021 in the following databases: Scientific Electronic Library Online (SciELO), US National Library of Medicine (NLM/Pubmed), Library Health Virtual (VHL), as well as government websites and reports from world conferences.

For the search, the following descriptors were used: Deep Venous Thrombosis; Oral Hormonal Contraceptive and Contraceptives. The Boolean term used associated with the words was AND.

The research was based on the following guiding question: What influence does oral contraceptive have on the emergence of deep vein

thrombosis? Thus, articles published between 2015 and 2021, in Portuguese (Brazil) and foreign language (English) translated into Portuguese were included, where the data were analyzed in detail in order to answer this question.

Preliminarily, the titles and abstracts were read to identify the articles that explained the subject. The objective, method, results and conclusions of each study were evaluated through analysis, where the year of publication and the journal of publication were taken into account. Subsequently, after a rigorous analysis, the studies that discussed the subject in full were identified and selected to compose the research.

Results and Discussion

The present work sought to describe the action of contraceptives associating their use with the emergence of deep vein thrombosis. After the selection of articles related to the topic, 11 articles from the last 7 years were included to compose the discussion. Data were analyzed and interpreted in order to answer the guiding question that guides the research. It is noted that most articles indicate that the emergence of DVT is linked to changes that these drugs cause in the hemostatic balance, in addition to factors such as the continued use of oral contraceptives composed of estrogen, age, weight and in women with a predisposition to the development of hereditary thromboembolic phenomena.

In 1994, the International Conference on Population and Development (ICPD) was held in Cairo. The conference resulted in an action plan aimed at improving people's lives and supporting family planning as well as sexual and reproductive health. The concept of reproductive health was defined as a state of complete physical, mental and social well-being. Within this concept, it was implicit that the person can have a safe sex life and have the autonomy to reproduce and decide how many times they want to do it. This decision is guaranteed by the right to have access to contraceptive methods of their choice.[7]

According to data collected in the national survey on demography and health of children and women, women are starting sexual activities at an earlier age. These data showed that by the age of 15, almost half of the women interviewed had already started their sexual life. Due to this beginning, it is necessary to choose a contraceptive method as well as the beginning of family planning.[8]

The action of contraceptives

The oral contraceptive is a revolutionary method discovered in 1961 with the main purpose of preventing a pregnancy. Over the years, these drugs have caused discussions, where science affronts society because of prejudices and taboos surrounding these drugs. These discussions drag on until today, without consensus. 50 years ago, Enovid, the first oral contraceptive, was approved. For some, a practical and affordable solution, but for others, a hormone pump with many side effects.[9]

According to data from the United Nations (UN), in Brazil, the contraceptive pill is the most adopted method by women due to the variety of combinations in different dosages of the hormones estrogen and progesterone.

These drugs are available in the Unified Health System (UHS) and in the pharmaceutical market.[10]

As the most used contraceptive method, these drugs are considered reliable and reversible. This confidence makes it more popular and easily accessible.[11]

The main objective of oral contraceptives is to inhibit ovulation through anovulatory reproductive cycles, thus resulting in the regular development of the proliferative endometrium without the production of the corpus luteum. Staying in this phase until the onset of menstruation.[12]

Contraceptives are made up of the synthetic hormones estrogen and progesterone that act in excess of ovulation-stimulating hormones. They help maintain hormone levels by inhibiting the secretion of FSH and LH through negative feedback resulting in preventing ovulation..[13]

Linkage of oral contraceptives with deep vein thrombosis

Venous thrombosis is a condition caused by the obstruction of a blood vessel due to excess structures composed of fibrin and platelets. This obstruction can occur throughout the body, and in 90% of cases the lower limbs are the most affected. DVT is caused in the deep veins, and it can be triggered by a number of factors. In Brazil, in 2015, 113,817 hospitalizations for thrombosis were recorded, where the data evaluated showed that the highest incidence of cases remained in females between 20 and 40 years of age, where the use of contraceptives is more frequent.[14]

DVT risk factors are classified as hereditary or idiopathic and acquired or induced. Hereditary factors present risks as resistance to protein C, hyperhomocysteinemia, increased bribrinogen, among others. Examples of acquired factors are obesity, myeloproliferative diseases, trauma and estrogen therapy.[15]

Thus, the risk of DVT associated with the use of oral contraceptives is linked to changes in hemostasis. Physiologically, estrogen increases the concentration of clotting factors and reduces protein S and antithrombin, which are anticoagulant factors. The risk of DVT associated with continuous use of oral contraceptives increases with the dose of estrogen, age, weight and in women with a predisposition to develop hereditary thromboembolic phenomena.[16]

The signs and symptoms present in DVT are: pain, edema, erythema, cyanosis, dilation of the superficial venous system, temperature increase, muscle swelling and pain on palpation. Studies recommend anamnesis and physical examination of the patient associated with laboratory and imaging tests. The Wells score is the most used clinical prediction system. This model consists of analyzing the clinical probability of developing DVT through a table where factors such as active cancer, paralysis, swollen whole leg, among others, are evaluated. Each clinical characteristic has a specific score and, at the end, the sum is made and, according to the resulting values, the risk is classified into low, moderate and high probability. The exams that complement the diagnosis are the D-dimer (DD), Color Doppler Echo (EDC), Venography/Flebography, Computed Tomography (CT) and Magnetic Resonance (MRI) tests.[15]

Blood stasis, hypergoagulability, endothelial damage and increased thrombin formation are factors that increase the chance of clotting and decrease inhibitors, causing a pro-coagulant effect resulting in DVT. Protein C is an anticoagulant that depends on vitamin K for inhibit blood clotting. The absence of an anticoagulant results in hypergoagulability, increasing the risk of venous thromboembolism. In general, the chance of developing DVT is in the first year that a woman uses the contraceptive. It is recommended that whenever there is a change of contraceptive, an anamnesis is carried out in the patient, in order to investigate and identify possible factors that trigger thrombosis.[13]

A survey conducted at the University of Brasília interviewed 100 women aged 18 to 40 years and identified that of these, 84 used oral contraceptives and 13 reported cases of thrombosis. Prevalence data indicated that the majority of cases prevailed among women aged 18 to 25 years. In this same study, it was observed that many women use contraceptives inappropriately and often without professional guidance. This action reflects the risks offered by these drugs, if they were used for long years. [17]

In this context, the use of oral contraceptives can increase the risk of deep vein thrombosis. Initially, the risk of thrombosis was related to the effects of estrogen on hemostatic factors, however, the risk of deep vein thrombosis (DVT) varies between contraceptives composed of progesterone. Due to the popularity and wide adherence to oral contraceptives, the increased risk of DVT is of concern and must be treated with great importance.[18]

Prophylactic measures

Several factors can increase the risk of thromboembolism, therefore, the choice of contraceptive must be made under the guidance of a health professional, as a family investigation is necessary to verify whether there is a family history of hereditary thrombosis. Therefore, the choice of method should be based on all data collected, which should consider the risk factors and benefits of the method.[19]

There is no consensus on the best contraceptive, however it is known that second-generation contraceptives (levonorgestrel and norethisterone) should be the first choice for most women, as they are safer than third- and fourth-generation ones.[16]

Therefore, it is concluded that these drugs increase the risk of blood clotting, which may be for hereditary or acquired reasons, thus causing DVT. It is recommended that each patient have individual medical monitoring in order to prevent future harm to women's health.[20]

Conclusion

Contraceptives emerged with the aim of giving women freedom, giving them the possibility to choose the right moment of pregnancy. Given the above, it is clear that contraceptives are drugs of first choice for most women, due to their accessibility. In general, these drugs are used inappropriately by most users, as in Brazil these drugs are sold without a medical prescription. This is a worrying factor, because like most drugs, contraceptives have side effects, especially since they are a combination of hormones.

With the elaboration of this work, we concluded that the prolonged use of these drugs can increase the risk of deep vein thrombosis, therefore, the user should seek medical advice, where her history and individual characteristics will be evaluated, resulting in the choice of the most appropriate contraceptive that meet your needs.

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Quality of life and work of the physiotherapist who works in the Intensive Care Unit and the effects on care

Qualidade de vida e no trabalho do fisioterapeuta que atua na Unidade de Terapia Intensiva e os reflexos na assistência

Calidad de vida y trabajo del fisioterapeuta que trabaja en la Unidad de Cuidados Intensivos y los efectos en los cuidados

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RESUMO
Objetivo: Analisar a qualidade de vida e no trabalho do fisioterapeuta que atua na UTI e os reflexos na assistência. **Método:** Revisão integrativa da literatura realizada no período de junho a agosto de 2021 nas bases de dados Medline, Scielo, Lilacs e Pubmed. **Resultados:** Foi realizado uma busca pelos descritores em saúde determinados e após análise sistemática dos artigos foram selecionadas 12 produções científicas que atenderam os critérios de inclusão**. Conclusão:** pode-se dizer que a qualidade de vida e satisfação no ambiente de trabalho dos fisioterapeutas precisa ser revisto e alguns aspectos melhorados para que possam realmente alcançar a qualidade de vida e satisfação ideais para que possam desempenhar o trabalho com eficácia.
Descritores: Qualidade de Vida; Fisioterapeutas; Unidade de Terapia Intensiva.

ABSTRACT
Objective: To analyze the quality of life and work of physical therapists who work in the ICU and the effects on care. **Method:** Integrative literature review carried out from June to August 2021 in the Medline, Scielo, Lilacs and Pubmed databases. **Results:** A search was performed for the determined health descriptors and after systematic analysis of the articles, 12 scientific productions that met the inclusion criteria were selected. **Conclusion:** Therefore, we can say that the quality of life and satisfaction in the work environment of physical therapists needs to be reviewed and some aspects improved so that they can really reach the ideal quality of life and satisfaction so that they can perform their work effectively.
Descriptors: Quality of Life; Physiotherapists; Intensive Care Unit.

RESUMEN
Objetivo: Analizar la calidad de vida y el trabajo de los fisioterapeutas que trabajan en la UCI y los efectos en la atención. **Método:** revisión integrativa de la literatura realizada de junio a agosto de 2021 em las bases de datos Medline, Scielo, Lilacs y Pubmed. **Resultados:** se realizó una búsqueda de los descriptores de salud determinados y luego de un análisis sistemático de los artículos, se seleccionaron 12 producciones científicas que cumplieron con los criterios de inclusión. **Conclusión:** Por tanto, podemos decir que es necesario revisar la calidad de vida y satisfacción en el ambiente laboral de los fisioterapeutas y mejorar algunos aspectos para que realmente puedan alcanzar la calidad de vida ideal y la satisfacción para que puedan realizar su trabajo de manera eficaz.
Descriptores: Calidad de vida; Fisioterapeutas; Unidad de Terapia Intensiva.

REVIEW

Introduction

The expression Quality of Life (QOL) requires a broad and generic understanding, making its use cross several themes, both technical and everyday. However, the World Health Organization (WHO) classifies the term as the individual's perception of his or her position in life, in the context of culture and value systems in which he/she lives and in relation to his/her goals, expectations, standards and concerns. This same institution reaffirms the subjective nature of the concept, constructed together with several experts, highlighting that the expression deals with the perception of each individual, which favors his personal and relative characteristic.[1]

The concept created to define Quality of Life encompasses all its complexity and relates factors intrinsic to the human being, namely: environment, physical, psychological aspects, beliefs, social relations, cultural context and level of independence. It is understood that the imbalance or threat to one or more of these elements directly influences the level of quality of life of the individual.[1]

However, in the literature they describe that the conception of Quality of Life remains controversial and there is still no definition that is accepted by all scholars of the theme. Several terms equate quality of life to attributes such as: satisfaction with life, well-being, health, happiness, self-esteem. Consequently, the dimensions of the concepts vary from study to study.[2]

Quality of Life depends both on the recognition of personal and social needs and on individual and collective action in response to or in anticipation of those needs. Individuals should develop perspectives, values and skills necessary to maintain the quality of their life in an appropriate and desired way in their community and culture that is socially integrated, cohesive, and that gives moral and material support when necessary.[3]

In Brazil, concern about the health of hospital workers began in the 1970s, when researchers from the University of São Paulo (USP) focused on occupational health in hospital workers. However, only in the 1990s, ethical and psychic aspects of work in the health area were taken into account. Despite this fact, diseases or complaints not related to work remain subject to a more accurate analysis to exclude their causal link related to the work process.[4]

Some authors state that the transformations in the productive processes that have happened in recent decades, the relations between work, stress and its repercussions on the mental health of workers have been researched with different methodological approaches and among workers from various professional categories.[5]

Work is a relevant activity in the health and life of individuals, in which physical and psychic aspects are directly related, through it man constitutes himself as a subject and maintains interpersonal relationships. The conditions and forms of organization of the work process can provide balance and satisfaction, as they can generate tension, dissatisfaction and consequently illness of the worker.[3]

Work is considered one of the most relevant and significant foundations in an individual's life, being inseparable from his own existence, being also seen as a means of insertion of the individual in society, encompassing a range of related physical and psychic aspects. The work is also responsible for ensuring the subsistence of the worker and his family, being an identity builder, however it

can acquire a harmful and pathogenic character or be a source of mental and physical health problems. Furthermore, the authors reiterate that with the current forms of work organization and productive restructuring, there was a huge increase in productivity and intensification of this, making the work environment generating new risks, resulting in greater demand and overload for professionals.[6]

The changes are characterized by increased work rhythm, long hours, time pressure, repetitiveness and monotony of tasks, interpersonal conflicts, social isolation, absence of decision-making power, as well as greater control of the workforce. Thus, the work requirements, related to the individual conditions of the worker, can have a negative impact on their physical and mental health.

Such changes in the universe of work have also influenced hospital institutions. Thus, there is a growing concern about the effects caused by work on health professionals. The psychic suffering tied to work in the hospital environment can affect all professionals, generating somatization, absenteeism, and the development of mental disorders, such as anxiety and depression.[6]

Emotional exhaustion, the responsibility to care, the fear of making mistakes, tiredness, the difficulty of the relationships established with the multidisciplinary team, culminate in a state of occupational distress, with significant psychological repercussions on the individual, as well as in his/her relationship with patients, generating feelings of dissatisfaction for the professional and external clients (family members and patients).[7]

When analyzing this relationship between man and work, it was observed that there are subjects who get sick due to the injunctions of work organization in psychic functioning. Therefore, the work can configure a source of illness because it contains risk factors for workers' health, since experiences of suffering and pleasure arise from this process of attribution of meanings. Pleasure occurs when conditions of psychological instability can be overcome, resignifying suffering. The pathological picture, in turn, points out flaws in the way of coping with suffering and settles when the desire for production overcomes the desire of the working subjects. In this context, the physiotherapy professional, also exposed to the harmfulness of work and the way it is organized, experiences pleasure and suffering in his routine.[8]

The intensive care unit (ICU) is a sector for the care of critically or at-risk patients who have uninterrupted care, with qualified professionals, specific equipment, specialized human resources, in addition to access to other technologies aimed at diagnosis and therapy, in this environment it is necessary to work multiprofessionally, with a team with doctors, nurses, physiotherapists, nutritionists, among others.[9]

These professionals, as well as other specialties in the health area, are exposed to significant physical and mental load during their work, with extensive working hours and a high psychological cost due to the close number of patients, not being uncommon in the category stress conditions and cases of Burnout Syndrome among others.[8]

Quality of Life depends both on the recognition of personal and social needs and on individual and collective action in response to or in anticipation of those needs. Individuals should develop perspectives, values and skills necessary to maintain the quality of their life in an appropriate and desired way in their

community and culture that is socially integrated, cohesive, and that gives moral and material support when necessary.[10]

Thus, the importance of Quality of Life also enters the work environment, because it is in this place that individuals spend most of their lives, therefore it is relevant and relevant the development of aspects that favor the care and development of the human being as a biopsychosocial being, recognizing their most varied and wide needs, in all areas of his life.

In recent years WQL (Quality of Life at Work), has been understood as the dynamic and contingency management of physical, technological and sociopsychological factors that affect culture and renew the organizational climate, reflecting on the worker's well-being and the productivity of the company, sometimes associated with the intrinsic characteristics of technologies introduced in companies and their impact; economic elements, such as salary, incentive, allowances, or factors related to physical, mental and safety health, and, in general, the worker's well-being.[11]

In general, some authors believe that the quality of life at work includes: pride in the work produced, income capable of meeting personal and social expectations, satisfactory emotional life, self-esteem, company/institution image with public opinion, work-leisure balance, sensible work schedules and conditions, career opportunities and prospects, possibility of using potential, respect for rights, and justice in the reward.[12]

Some scholars have affirmed the dual character of human work as a means and purpose in itself. As a means, work gives resources to man to acquire goods necessary for life, and finally, to socialize man, to place him in front of the other and, therefore, before him.[13]

In addition, quality of life at work is also of utmost importance for workers who have growth goals in their careers. When the quality of life at work is high, the trend is more delivery and passion for the activities performed.[14]

Worker satisfaction does not depend exclusively on the company, as everyone has their lives, difficulties and goals outside the corporate environment. But creating a culture focused on worker support, development and well-being is a big step for everyone to benefit. It is very important to emphasize that the human being brings with him feelings, ambitions, creates expectations, engages, seeks growth within what he develops and accomplishes. Much has been said about quality of life at work, but job satisfaction cannot be isolated from the life of the individual as a whole.[15]

As for professional satisfaction or satisfaction at work Batista (2020) mentions that it can be conceptualized as a pleasant feeling or positive emotional state of the worker, resulting from the perception/evaluation of his work experience, according to his personal values and also his/her goals, and may be modified or influenced by internal or external forces to work.

In view of the above, the choice of the theme is justified by believing that in the area of physiotherapy studies focused on quality of life at work is scarce, especially tied to the work of the physiotherapist in icUs.

The physiotherapist, as a component of the health teams of ICUs when performing their daily activities, is in different situations that can compromise their health. In this sense, one can focus the relationships of physical therapists with their work environment, not only in relation to the environment itself, but

also their social relationships, work instruments, the activities performed by them and the work organization itself.

Therefore, the need for the physiotherapist to be in balance and satisfaction with his/her work, because when the worker attributes positive meaning to his work, he remains motivated and acts efficiently.

Thus, it is believed that this theme can contribute to the performance of physical therapists so that they can identify the aspects that compromise care and possible action strategies aimed at eliminating these damages.

In this sense, the aim of this study was to analyze the quality of life and work of the physiotherapist who works in the ICU and the reflexes in care.

Method

Integrative literature review study, whose method provides the synthesis of knowledge and the incorporation of the applicability of results of significant studies in practice.[16]

For the preparation of this review, the following methodological procedures were followed: formulation of the question and the objectives of the review; establishment of criteria for the selection of articles; categorization of studies; evaluation of the studies included in the integrative review; analysis of the data and presentation of the results.

Integrative review of the literature conducted from June to July 2021. A systematic research of the literature published between January 2016 and May 2021 was conducted through the Virtual Health Library (VHL) and the Medical Literature Analysis and Retrievel System Online (Medline), Scientific Electronic Library Online (Scielo), Latin American and Caribbean Literature in Health Sciences (Lilacs) and Pubmed were used.

The descriptors used were "Quality of Life"; AND "Physiotherapist"; AND "Intensive Care Unit; AND "Patient".

The inclusion criteria were: the studies that described the main characteristics of quality of life in the Intensive Care Unit by the physiotherapist; the characteristics of stress and burnout syndrome that affect the physiotherapist intensivists barriers and the profile of the physiotherapist who works in ICUs and the possible factors that can impact the quality of life of this professional; documents written in Portuguese, English and Spanish; available in full text and free of charge; publication date between January 2015 and May 2021. All studies that did not meet these criteria were excluded from the study.

Results and Discussion

With a total of 100 articles identified in the databases, 30 documents previously for review were analyzed according to the inclusion and exclusion criteria, of which 6 were selected for the study and that met the research objective (Chart 1).

Table 1- Articles selected for the study, according to: author/year, title and objective.

Author/Year	Title	Objective
Camargo, Gonçalves e Mazzo (2019)	Evaluation of the satisfaction of physical therapy in a hospital environment	To evaluate the degree of satisfaction regarding the physiotherapeutic care of patients hospitalized in the wards of the Regional University Hospital of Campos Gerais (HURCG).
Dantas e Lima (2019)	Stress level and quality of life in physiotherapists working in intensive care units	Evaluate the level of stress and quality of life in intensivist physiotherapists and correlate with weekly workload. Methods: Cross-sectional study conducted with 56 physiotherapists working in ICUs
Nascimento et al. (2017)	Burnout syndrome in intensivist physiotherapists	Evaluate the presence of aspects related to Burnout Syndrome in intensivist physiotherapists from Vitória da Conquista-BA and correlate with their quality of life.
Rocha et al. (2019)	Professional exhaustion and job satisfaction in emergency and intensive care workers in a public hospital	Estimate factors associated with the prevalence of Burnout syndrome (BS) and job satisfaction (TS) of emergency room and intensive care center (ICU) teams of large public hospital.
Santos, Neri e Wanderley (2018)	Burnout syndrome in physiotherapists of a public hospital of high complexity in the city of Recife, Pernambuco	To investigate the frequency of BS in physical therapists of a public hospital, verifying associations with demographic and labor variables.
Silva et al. (2018)	Burnout syndrome: reality of intensivist physiotherapists?	To evaluate the profile and prevalence of Burnout syndrome in intensive care physiotherapists in public networks in the city of Recife, comparing them between adult, pediatric and neonatal units.

Quality of life and job satisfaction have stood out as one of the main topics of study nowadays due to the growing interest of institutions in retaining and valuing human capital.[17]

Satisfaction is responsible for personal and organizational growth and development, and is achieved when we achieve a desired result, being one of the main indicators of QVT.

The study points out that for there to be quality of life at work outside and within the company, several measures are necessary: adequate and fair compensation, without a living wage, there is no personal satisfaction; safety and health conditions at work: workload and an appropriate at-work environment; immediate opportunity for the use and development of human capacity; opportunity for continued growth and security; social integration in the organization; constitutionalism in the organization of work; work and total space of life; the social relevance of life at work.[17]

Health professionals, especially physical therapists, are part of a group of professionals exposed to excessive tension states: frequent emergency situations, numerous risk conditions and circumstances that provide the constant need for the right, and these are some of the factors that justify the high probability of occupational stress in the class.[18]

The research shows that there are preventive measures that can be applied in the scope of professional practice and the psychologist can collaborate emphasizing the need for investment in a work focused on stimulating the growth and improvement of professionals, through team activities, such as training and case discussion groups with the participation of the various areas of knowledge involved in care, providing the circulation of information, interdisciplinarity and better conduct.[18]

The differences in training of professionals in each area can be adapted and integrated in the form of development of protocols or therapeutic programs, elaborated by the technical team itself, and offered to the clientele in an organized and productive way, within the real and possible, ensuring a good flow in the use of resources, where the fields of knowledge do not overlap and the conducts and procedures integrate in a harmonious and efficient way for patients and staff.[18]

Caring for ICU patients can bring numerous psychological gratuities when improving the patient's condition (success), but it also brings the need to face the numerous frustrations (successes) with important repercussions on the mental health of physical therapists.[19]

Some authors assure that in icuss, physical therapists are exposed to occupational risks and loads that can impair their quality of life and even result in the emergence of work-related diseases. These diseases can bring dissatisfaction and unhappiness to the professional in their daily activity. The physical therapist's performance is a specialty in which stress factors triggered by the dynamism in the care of patients in severe condition are present. Living with suffering and death is capable of generating feelings of helplessness in these professionals.[20]

Thus, the importance of quality of life in the work environment, having as definition the set of factors present in a given institution, enabling the worker of this scenario the complete development of their physical, intellectual potentialities associated with physical, mental, material and social well-being, respecting the principles of safety, hygiene and ergonomics, allowing each individual to achieve their citizenship rights.[21]

In the organizational scope, quality of life is an extremely important theme, because it directly interferes in the issue of competitiveness, space in the market, productivity of the company. In this context, the quality of life at work can be understood as the involvement of people, work and organizations, where the concern for the well-being of the worker and the efficiency of the organization are the most relevant aspects.[17]

Health organizations need to offer more incentives for physical therapists: career plan, better salaries, dignity to be able to support their families. And above all respect for this profession that has as main goal to take care of others with technique, respect, competence and affection.[22]

Efforts to improve QOL contribute to making positions more productive and satisfactory, since QOlT is affected by several factors such as sensible

working hours and working conditions, career perspective, satisfactory salaries and benefits, satisfactory emotional life, self-esteem, work-leisure balance, among other factors, however, job satisfaction is not isolated from the life of the individual as a whole. Quality of life at work is the major determinant of quality of life and life without work has no meaning. Work must therefore be seen as an inseparable part of life and a determinant of personal identity.[22]

However, currently the market has required professionals with a profile adaptable to various performances. However, such demands can generate impacts on workers' health, such as physical and psychological imbalances. These, in turn, promote the increase of the stress level and the decrease in the performance of tasks, and may have repercussions on the quality of work. Health professionals in general are examples of individuals often exposed to high physical and mental load during work.[19]

In recent decades, intensive care units (ICUs) have become a concentration not only of critical and advanced technology patients, but also of an experienced multidisciplinary team with specific skills. The physical therapist, as a member of this team, increasingly needs improvement and specialized education to face the advance of intensive care.[19]

Psychological stress is developed when external demands of individuals exceed their abilities. If excessively present, it has deleterious effects, leading to the feeling of overload and may result in insomnia, fatigue, irritability, anxiety and depression. Working in intensive care units (ICU) is especially stressful due to the high morbidity of patients. In addition, there are also limited time and resources to serve them in some cases.[19]

Other factors such as tiredness, a constant state of alertness, dealing with family members with proper skills, excessive workload, unpredictability, in addition to ethical dilemmas, are also some subjective sources of stress in ICU.[19]

Regarding the mental fatigue generated in the ICU, two major problems are noted: Burnout Syndrome and Secondary Traumatic Stress, both associated with situations of traumatic stress or progressive and/or continuous stress. Burnout syndrome is a psychic disorder that is linked to a person's work and/or function, and can become a chronic source of emotional stress.[21]

The chronic stress present in the routine of health workers, different from the common stress, causes emotional and/or physical problems in the workplace. The physical and mental tension caused in this environment is what leads them to Burnout syndrome. This syndrome is a disorder characterized by emotional exhaustion, depersonalization and reduced professional achievement, which can occur with professionals working mainly in care functions, which require great investment in interpersonal relationships and are marked by care and dedication.[21]

The professional who suffers from this syndrome feels exhausted, is often ill, suffers from insomnia, has ulcers, headaches, muscle tension, and chronic fatigue. It may present association of other pathologies, such as psychiatric diseases, depressive disorder and cardiovascular problems. There has also been an association with increased consumption of tranquilizers, antidepressants, drugs and alcohol. For all these findings, burnout syndrome is currently pointed out as an essential issue in public health.[20]

The second burnout is a psychological syndrome, of professional snare, caused by chronic work-related stress in workers who present direct and

prolonged contact with other human beings and propitiate the appearance of the multidimensional factors of the syndrome: emotional exhaustion, affective distancing (depersonalization), low professional achievement (inefficacy), and exhaustion is the precursor dimension of the syndrome, followed by depersonalization and, finally, by the feeling of diminishing personal fulfillment at work.[19]

This syndrome affects health professionals and results in increased absenteeism due to psychological diseases, comorbidities and even the abandonment of the profession. All this causes an overload in the daily lives of co-workers, increased costs for institutions and, consequently, for public health.[21]

Final Considerations

Considering that the intensive work of physical therapists reduces the risk of complications and hospital infections, reduces the suffering of patients and, consequently, allows the faster and safer release of hospital bed vacancies, it also implies the cost of health in general.

The analysis performed in the articles selected for this study showed the importance of the physiotherapist and multidisciplinary team in maintaining their quality of life, as this directly affects their professional practice and consequently will reflect on the patient in a negative or positive way.

Therefore, the studies demonstrate the importance of quality of life and the impact on the care of the physiotherapist in the occupational environment, and how much the themes deserve attention, because psychological damage generated by excessive or overly stressful work can directly interfere in the work performance, compromising quality and safety in general.

A work environment that favors the balance between personal and professional life, which seeks the valorization of the professional, creates a safe and conducive environment for the exchange of experiences, respect among professionals and sharing of tasks and functions, will certainly reflect on the good performance in the care provided by physiotherapists to patients, family members and multidisciplinary team.

Therefore, it is necessary to analyze these issues by the institutional and personal/professional spectrum, linked to the actions of analysis and discussions on the dimensioning of weekly workloads and the number of people trained to repute this professional in their rest, training and better work resources so that this professional can work safely, with quality and psychological support.

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Communication between nursing and patients in an intensive care unit: dilemmas and conflict

A comunicação entre a enfermagem e os pacientes em uma unidade de terapia intensiva: dilemas e conflitos

Comunicación entre enfermería y pacientes en una unidad de cuidados intensivos: dilemas y conflictos

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RESUMO
Objetivo: Refletir sobre o papel do enfermeiro sobre o modo como ocorre o processo comunicacional em UTI na relação com os pacientes sob seus cuidados através da relação dialógica. **Método:** Revisão integrativa da literatura realizada no período de junho a agosto de 2021 nas bases de dados Medline, Scielo, Lilacs e Pubmed. **Resultados**: Foi realizado uma busca pelos descritores em saúde determinados e após análise sistemática dos artigos foram selecionadas 10 produções cientificas que atenderam os critérios de inclusão. **Conclusões:** Portanto, podemos dizer que a comunicação é uma ferramenta importante na prática cotidiano da enfermagem possibilitando acolhimento, humanização, aceitação do tratamento, segurança do paciente contribuindo para uma asssitencia eficiente e de qualidade.
Descritores: Comunicação; Humanização; Assistência.

ABSTRACT
Objective: Reflect on the role of nurses on the way the communication process occurs in the ICU in the relationship with patients under their care through the dialogical relationship. **Method:** Integrative literature review carried out from June to August 2021 in the Medline, Scielo, Lilacs and Pubmed databases. **Results**: A search was carried out for the determined health descriptors and after systematic analysis of the articles, 10 scientific productions that met the inclusion criteria were selected. **Conclusions:** Therefore, we can say that communication is an important tool in daily nursing practice, enabling reception, humanization, acceptance of treatment, patient safety, contributing to efficient and quality care.
Descriptors: Communication; Humanization; Assistance..

RESUMEN
Objetivo: Reflexionar sobre el papel de las enfermeras en la forma en que se da el proceso de comunicación en la UCI en la relación con los pacientes a su cargo a través de la relación dialógica. **Método:** revisión integrativa de la literatura realizada de junio a agosto de 2021 em las bases de datos Medline, Scielo, Lilacs y Pubmed. **Resultados**: Se realizó una búsqueda de los descriptores de salud determinados y luego de un análisis sistemático de los artículos, se seleccionaron 10 producciones científicas que cumplieron con los criterios de inclusión. **Conclusiones:** Por tanto, podemos decir que la comunicación es una herramienta importante en la práctica diaria de la enfermería, posibilitando la recepción, humanización, aceptación del tratamiento, seguridad del paciente, contribuyendo a una atención eficiente y de calidad.
Descriptores: Comunicación; Humanización; Asistencia.

REVIEW

Introduction

The communication process occurs through the accumulated experience of numerous small events in which, interconnected, facts and people teach human beings to orient themselves in the social world in a natural and convenient way.[1]

During our life, we establish interpersonal relationships in which our feelings, values and beliefs are expressed, with an exchange of experiences between family and friends, at work and in other social groups and environments, and the need to use words, gestures and the dance itself. body to express itself. A dance of steps, gestures, feelings and postures so unique that the most astute observer transmits energy, feelings and desires.

During our life cycle, however, we may go through an experience in which the process of verbal communication is limited, that is, for a period of time, we are simply not in a position to express ourselves verbally.[2]

This situation is common in the ICU (Intensive Care Unit), when the patient uses advanced life support, and to communicate only gestures, looks, often incomprehensible, covered by the anguish in trying to make himself understood. On the other hand, there are the attempts, which are often frustrating by nursing workers to understand the patient under their care.[3]

The interaction can be more difficult with the patient intubated, in a coma, or even with an altered level of consciousness. However, dealing with a lucid and oriented patient is also a situation that requires sensitivity, as being hospitalized in an ICU can have several meanings, directly affecting their lifestyle when they resume their usual activities[3].

On the one hand, there is the patient facing a crisis as a situation in which the person becomes unbalanced, as he/she faces an obstacle that comes before their life goals. On the other hand, there is the nurse who supports the patient, seeking to reduce the anxieties and tensions generated by this incapacity, momentary or not.[1]

Nursing, through its workers, by its own conception, by the intensity and frequency of the activities performed, constitutes a bridge between the critically ill patient and the surrounding environment. In this way, communication is for nursing a basic instrument, a competence and skill to be developed.[4]

In ICU, the patient has a level of consciousness that varies from lucid and oriented to deep coma, although there is no clear definition of its limits, as this level of consciousness can vary. The fact that the patient is experiencing a critical situation does not mean that he is unaware of his problem, much less his ability to feel, see and hear, which become more acute, as interest in himself and in his survival is a priority. in this situation.[5]

Therefore, the communication process must be seen as a possible way for human beings to transmit their way of living and feeling their culture, revealing their condition of being, through empathy, acceptance and emotional involvement present in the interaction between nurses and the patient.[4]

It is believed in the importance of the theme for nursing and in the value of each one's experience as a source of knowledge and a way to add the dialogical relationship to daily practice. Therefore, it is necessary to create an interaction with the patient, rethinking the communication process and its implications during the provision of care.[5]

The search for dialogic interaction implies knowledge of the situation of human beings, leading nurses to delve into reflections and practices that can collaborate for a more humanized performance.[2]

Moreira reinforces that using communication, nurses seek to identify the needs of patients, inform them about procedures or situations that are of interest to them, carry out health education, exchange experiences and promote changes in behavior. It is through established communication that he deciphers what patients want to say and make themselves understood, leading to effective interaction between patients and professionals. For this to be possible, care must be taken to ensure that communication is appropriate to a given situation, person, time and place.[1]

Communication is necessary in nursing practice, but even though it is essential in the exercise of professional practice, it is not always carried out, as several negative aspects interfere in the communicative action of those involved. In addition, communication is important in nursing care and determines the quality of the nurse-patient relationship in order to achieve the purposes of nursing. Thus, it is essential to understand that communication strategies need to be present in nursing practice.[6]

Nurses need to plan, organize, coordinate, execute and evaluate nursing care services, in accordance with the law of professional practice, so that care is effective. Thus, the work of the nursing team can be considered interdependent, as events related to nursing actions, that is, nursing care, need integration between all professionals. Thus, communication is an important ally to facilitate this integration and consequently assist in care.[6-7]

Communication between the nurse and the patient is a key and essential element in care. Communication, in its various forms, plays the role of an instrument of humanizing significance and, for this, the nurse needs to be willing and involved to establish this relationship and understand that it is essential to recognize the patient as a subject of care and not passive to him. [8]

Intensive care units (ICUs) have the function of offering patients who need intensive care continuous and permanent assistance to obtain, recover and maintain their health conditions. These units still play a large role in determining the quality of life that these patients will have in the post-discharge period. Therefore, during care in specific units like these, a trained and efficient nursing is needed.[8]

Restrictions on movement, barriers to speaking (tubes and probes), and the fact of not having explanations about their treatment can lead to stress for the patient. Therefore, the nurse-patient communication must be established as something essential and fundamental, especially with the sedated patient, as he or she may not identify what is happening around them on their own.[7]

Thus, it is necessary to have the ability to communicate for the development of work in the rescue of care as a process of respect and appreciation of the human being. Communication facilitates care and the patient-nurse relationship, generating changes in their behavior, based on effective actions to understand the sick person[8,9].

Thus, nursing professionals must effectively use communication as the main instrument for quality care. For this, the nurse must be knowledgeable about the forms of communication, exploring both the verbal and the non-verbal, thus arousing feelings of confidence, encouragement and patient satisfaction[10].

Thus, it is essential that professional nurses seek to be knowledgeable in communication techniques so that they can develop specific actions to care, understanding and understanding how the patient perceives the events around them, and how this view influences their conduct in face of the reality of oneself. Thus, it is only through communication that it is possible to understand the patient as a whole and identify the meaning that the health problem has for him. Nurses, knowing the appropriate therapeutic communication techniques, have one more resource in their favor, giving a humanistic approach to communication and the interpersonal relationships they maintain[9].

Some factors were identified as contributing to poor communication, and among these we have inadequate time to build this process, the lack of consistent information, inadequate information that is provided by various professionals, affecting the psychological results of patients and family members, especially when in terminal phase [11].

Nursing professionals working in the ICU are required to have high communication skills, allowing them to recognize the emotional, physical and psychological issues of these patients. Therefore, the development and use of knowledge in communication can be useful, such as lip reading, attention to silent words, comprehension of gestures, the use of pen and paper and alphanumeric charts, among others, have been described as promising for facilitating the assistance provided[11].

The nurse, as the professional who has the greatest contact with the patient and their relatives, is responsible for meeting the demands of the families, hence the need to establish a bond and strengthen the dialogue with the patient's relatives. There is no way to think about care without considering the importance of the communicative process, but communication is subject to difficulties that compromise its transmission, reception and interpretation. Hence the need to establish adequate communication, in order to reduce doubts and conflicts[12].

In this sense, the aim of this study was to reflect on the role of nurses on the way the communication process occurs in the ICU in the relationship with patients under their care through the dialogical relationship.

Method

Study of integrative literature review, whose method provides the synthesis of knowledge and the incorporation of the applicability of results of significant studies in practice.

For the preparation of this review, the following methodological procedures were followed: formulation of the question and the objectives of the review; establishment of criteria for selection of articles; categorization of studies; evaluation of studies included in the integrative review; analysis of data and presentation of results.

Integrative literature review conducted from June to July 2021. A systematic search of the literature published between January 2016 and May 2021 was carried out through the Virtual Health Library (VHL) and the Medical Literature Analysis and Retrievel System was used Online (Medline), Scientific Electronic Library Online (Scielo), Latin American and Caribbean Health Science Literature (Lilacs) and Pubmed. The descriptors used were “Communication”; AND “Humanization”; AND “Barriers”.

The inclusion criteria were: studies that described the main characteristics of Communication in the Intensive Care Unit by nurses; the barriers that hinder communication to take place efficiently and the family members facing communication in the Intensive Care Unit; documents written in Portuguese, English and Spanish; available in full text and free to access; publication date between January 2017 and May 2021. All studies that did not meet these criteria were excluded from the study.

Results and Discussion

With a total of 120 articles identified in the databases, 30 documents were analyzed according to the inclusion and exclusion criteria, previously for review, of which 6 were selected for the study and that met the research object (Table 1).

Table 1. Articles selected for the study according to author/year, title and objective. 2021.

Author/Year	Title	Objective
CATAPRETA, et al. (2020)	Communication in the oncology intensive care unit: A systematic review of the biases that interfere and/or participate in communication between nurses and cancer patients	Raise and discuss biases that may interfere or participate in communication between nursing professionals and cancer patients hospitalized in the intensive care unit
COSTA, et al. (2018)	Communication between nurses and family members in the ICU: an integrative literature review	Know the scientific production about communication between nurses and family members in an intensive care unit.
FONTENELE, et al. (2019)	Ineffective communication and its consequences for critically ill patients	Identify the main problems related to ineffective communication and its consequences for the health of critically ill patients in the intensive care unit.
WITISKI, et al. (2019)	Communication barriers: perception of the health team	To apprehend the health team's perception regarding communication barriers and identify factors that contribute or interfere in the health team's communication.
FARIAS; SANTOS; GÓIS (2017)	Effective communication: a link in patient safety in the hospital environment	Identify scientific production on effective communication in the hospital environment in the period of 2006-2017.
RESESTELATO;	Communication between	Demonstrate the relevance of

HOFFELDE (2018)	family members and the ICU nursing staff associated with quality of care: case report	the humanization of care in the Intensive Care Unit.

The data collected in the selected articles and described in the table above, demonstrate that communication in the intensive care unit contributes as an instrument that facilitates humanization to take place in the relationships between nurses and patients, representing a reciprocal process of exchange of matter and energy, which should be conducted in a dialogic relationship, where emotions need to be present, respect for the feelings and interests of each person, understanding of affective and cognitive aspects, in addition to the need for nurses to recognize patients' feelings and emotions, without straying from their therapeutic role .[12]

Communication is essential for humanized care, it is a form of respect created by nurses during care, when using listening and adequate care during technical procedures. During nursing care for the patient, the constant dialogue between them cultivates trust, respect and empathy, contributing to the restoration of the patient's health.[13]

Nurses must have theoretical knowledge about communication and acquire interpersonal relationship skills in order to act positively in patient care. Among these knowledge and skills are knowing how to listen, speak, and let the patient interact in this relational process, showing interest during the exchange of messages, and in this way identifying problems and making improvements for patient care.[14]

There are several strategies that can be used, including: planning and individualization based on the patient's needs, identifying the patient's needs at that moment; the explanation of the procedures or situations he wants to know about; the promotion of relationships between patients who are in the same sector; the interaction with the multidisciplinary team and with family members who are part of their patient context.[15-16]

These strategies consist of fundamental instruments in the care process between nurses and patients, facilitating and helping the development of the nursing process, and thus, the reality of care. Other aspects need to be observed, such as: the use of silence, the expression of their attention, the offer of an element of help, the encouragement for the patient to interact with the subject, the encouragement of their perceptions and comparisons, the exploration of a subject, clarifying ideas, expressing doubts, encouraging evaluation, among others.[16]

Communication is considered a complex process, where the possibility of sending or receiving incorrect messages is constant. In the health area, verbal and non-verbal communication is one of the main tools for the development of effective care. For this reason, it is essential that nurses have knowledge about the components of the communication process and their impact on the relationships established between them, patients, staff and other professionals, as a way to improve the practice, maximize the positive effects and prevent or minimize miscommunication mistakes, preserving the patient's integrity and well-being.[16]

Therefore, communication is one of the skills that nurses need to use in

order to understand the implicit or explicit messages that permeate the relationship with the patient.[17]

The factors that cause communication barriers are many and include: work overload, lack of privacy, lack of training, specialization of professionals working in the same unit, embezzlement in the team, different languages, even the length of work and professional experience can influence in communication between professionals.[17]

Given these factors, it is essential that nurses are in constant search for improvement and that they master the communication process and how to use it effectively.[12]

Communication not always effective increases the difficulty in the daily life of the profession, it should also be noted that the use of hard technologies in the intensive care environment requires different training to ensure the proper use of devices in favor of patient safety, as the lack of knowledge and communication between the teams hinders the understanding of the clinical context of the patient's improvement or worsening.[15,17]

Actions are recommended so that the communication process is effective, including the involvement of hospital management, in addition to using leadership competence as a means of leading the group, aligning organizational processes in order to optimize the flow of information and thus ensure safety of the assistance offered. In order to achieve this objective successfully, it is necessary to develop employees through continuous training. This will underpin the decision-making ability in processes involving patient safety.[13]

Therefore, it is necessary that the teams are directed towards the common objective, which is the patient's well-being, and seek to work in a harmonious and integrated manner. The attitude of the nurse as the one who must guarantee the quality of communication between patient, family and team. It means having an active listening to the other, understanding them in their uniqueness, in their needs, so that they feel recognized.[12]

The ICU is not just a service with special equipment. In it, one of the main factors is the provision of assistance, through an interpersonal relationship, which must take place through verbal or non-verbal communication. In this context, it is expected to be offering security and effective emotional support to the client and their family, combined with an attitude oriented towards the use of existing technological resources.[12]

Communication is part of the daily routine of nursing, and it is considered a fundamental basic instrument used by nurses, whether in patient care, family care or in relationships with the work team. It is necessary to work on communication with the family to enhance patient and family care; it is necessary to guide them about the ICU environment, equipment, patient status; question her about her doubts; observe her reactions and behaviors; understand your emotions. It is known that family members, when well prepared, are able to spend more time with their family member and be involved

in the recovery process, which, in addition to benefiting them, reduces the feeling of helplessness.[14]

However, communication between nursing professionals and family members of patients admitted to the ICU goes through some difficulties that need to be overcome. When family members start to live with and actively participate in the hospitalization and healing process of their relatives, they better accept all the treatment, equipment and procedures.

So that we can explore the peculiarities that involve patient care in the ICU, it is necessary to understand that human beings are not isolated, that is, they develop in different environments, with different people and who carry a whole cultural and social baggage. In this context, the family, as an extension of the patient, must be included in their therapeutic plan, requiring effective communication with the Nursing team, which will bring great benefits to the patient, family and health team and will contribute to a more humanized care .[13]

It is important that nurses establish a good relationship with the family, thereby creating a feeling of trust, but we must be aware of the real needs of the family, being "open" for dialogue, questions, helping them to understand and face the situation of the patient.[14]

There is a need to value the presence of the family in the care provided, especially when they experience the hospitalization of a family member in the ICU. Even when the family is in a state of emotional fragility or crisis, it continues to play a prominent role for the patient, helping them to feel protected, more secure, loved and meaningful to their family group; such feelings, most of the time, encourage him to fight for life.[11]

Quality interaction and communication between nurses and patients' families is of paramount importance; as they provide the clarification of these, in addition to establishing an emotional bond that consequently promotes the optimization of care and initiates a primordial process in nursing: humanizing communication.[17]

Through communication, a bond of trust and understanding can be established between the nursing team and family members. The team, in addition to guiding and informing the latter, will be able to provide the alleviation of their anxieties and improve the understanding of the health-disease process of patients admitted to the ICU.[17]

For those unfamiliar with the hospital environment, the ICU is considered a critical place where “people go to die”; “when they are at their last” or “when they are very low”. Stereotypes such as these could also be undone through efficient communication.[14]

It is important that the nursing team instruct family members well and show them that the ICU obviously does not mean the patient's death, but a place where attention and care are more intense; explain the importance of good communication for ICU patients, showing family members the encouragement they can provide to their loved ones through optimistic, encouraging

conversations and, mainly, dialogues that express the importance the patient has for complete harmony of the family.[13]

The entire communication process is carried out through the instructions that the nurse gives the family about the patient's health status, the technical procedures used, the client's response to treatment, the standards and routines of the ICU of that institution, in addition to alleviating or clarify any doubts that family members may have regarding the disease, providing a better understanding of it, through an easy-to-understand language for the patient.[12]

The need to adopt an effective communication system with the relatives of patients admitted to the ICU is evident, as a way to contribute to the humanization of care for this clientele. In this sense, the nurse will be adopting new forms of care, which include, in addition to meeting the basic needs of the client, arising from the disease and technological devices, valuing family members as an integral part of nursing care from the perspective of the humanization of care.[12]

Final considerations

Through the research, the importance of communication for nursing professionals was found, especially those who are directly linked to work in the Intensive Care Unit, which represents a complex environment with its own characteristics.

When well used, communication promotes the close relationship between patient-nurse and team, facilitating the work of nurses, as they will have greater possibilities to interact and learn about the reactions, emotions, fears, anguish and expectations of the patient and family, and thus act with more security and humanization.

It is important that nurses review the way they have been using communication and try to break the barriers that prevent communication from taking place in a clear, objective and effective way, and seek alternatives that promote care and strengthen emotional bonds and, consequently, they will be promoting the quality of patient care.

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The nursing care to the parturient in the hospital context: a look at obstetric violence

A assistência do enfermeiro à parturiente no contexto hospitalar: um olhar sobre a violência obstétrica

El cuidado de enfermería a la parturienta en el contexto hospitalario: una mirada a la violencia obstétrica

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RESUMO

Objetivo: Analisar a recorrência da violência obstétrica, elucidar a heterogeneidade deste tema, compreender o tratamento recebido pelas pacientes, e discorrer a visão da enfermagem frente à Violência obstétrica. **Método**: Metodologia descritiva; revisão bibliográfica a partir da plataforma *Google* Acadêmico, embasada em artigos publicados em bases científicas como SciELO, PubMed, Lilacs, etc., com abordagem qualitativa. **Resultados:** Trata-se de qualquer ato exercido por profissionais da saúde no que cerne ao corpo, aos processos reprodutivos e ao psicológico das mulheres, exprimido através de uma atenção desumanizada, abuso de ações intervencionistas, medicalização e a transformação patológica dos processos de parturição fisiológicos. **Conclusão:** Foi possível compreender que há necessidade da criação de leis rigorosas que concretizem o conceito de Violência obstétrica e puna os responsáveis por praticá-la, mais pesquisas e debates envolvendo este tema, orientações a respeito dos direitos das grávidas, parturientes e puérperas, fiscalização rotineira das instituições e a busca pela educação continuada.

Descritores: Assistência; Violência obstétrica; Enfermeiro; Puérpera.

ABSTRACT

Objective: Analyze the recurrence of Obstetric Violence, elucidate the heterogeneity of this theme, understand the treatment received by patients, and discuss the view of nursing in relation to Obstetric Violence. **Method:** Descriptive methodology; bibliographical review using the Google Academic platform, based on articles published in scientific databases such as SciELO, PubMed, Lilacs, etc., with a qualitative approach. **Results**: It is any act performed by health professionals regarding the body, reproductive and psychological processes of women, expressed through dehumanized care, abuse of interventionist actions, medicalization and the pathological transformation of physiological parturition processes. **Conclusion:** It was possible to understand that there is a need to create strict laws that implement the concept of Obstetric Violence and punish those responsible for practicing it, more research and debates involving this topic, guidance on the rights of pregnant women, parturients and postpartum women, inspection routine of institutions and the search for continuing education.

Descriptors: Assistance; Obstetric Violence, Nurse; Postpartum.

RESUMEN

Objetivo: Analizar la recurrencia de la violencia obstétrica, dilucidar la heterogeneidad de este tema, comprender el trato recibido por los pacientes y discutir la visión de la enfermería en relación a la Violencia Obstétrica. **Método:** Metodología descriptiva; Revisión bibliográfica mediante la plataforma Google Academic, basada en artículos publicados en bases de datos científicos como SciELO, PubMed, Lilacs, etc., con un enfoque cualitativo. **Resultados:** Es todo acto realizado por profesionales de la salud en relación con los procesos corporales, reproductivos y psicológicos de la mujer, expresado a través de cuidados deshumanizados, abuso de acciones intervencionistas, medicalización y transformación patológica de los procesos fisiológicos del parto. **Conclusión:** Se pudo entender que existe la necesidad de crear leyes estrictas que implementen el concepto de violencia obstétrica y sancionen a los responsables de practicarlo, más investigaciones y debates en torno a este tema, orientaciones sobre los derechos de las mujeres embarazadas, parturientas y posparto. la mujer, la rutina de inspección de las instituciones y la búsqueda de la educación continua.

Descriptores: Asistencia; Violencia obstétrica; Enfermera; Puerpera.

REVIEW

Introduction

Giving life to an individual encompasses physical, biochemical or psychological factors and marks the lives of all involved, who express expectations, fears, doubts, uncertainties, but usually, the pregnant woman is the element that goes through these variations the most. Since the beginning of the pregnancy period, the woman undergoes transformations throughout her body and mind and, therefore, should receive care and respect from everyone around her, not excluding health professionals here.[1-4]

Due to the complexity of the gestational period, including childbirth, care for pregnant women, parturient or postpartum women should be based on ethics and the Holistic Model, which supports quality care, understanding women as a subjective being that must be respected in all aspects, considering her as an active being of the whole process.[1]

Regarding frequency, there are reports of women who have had prenatal care, childbirth or puerperal period with violence, with labor itself being the largest sum of traumatic experiences for them, and the present research work will focus on the latter.[16]

Obstetric violence, as a major risk factor for maternal and fetal mortality, must be combated, among other measures, to achieve the effective reduction of these rates, increasing the quality of obstetric and neonatal care, and achieving reliability in health professionals by pregnant women.[26]

Within this concept is any act of impetuosity in the woman's body, such as the touch procedure performed in a brutalized way, causing more pain and genital injuries; or even the maneuvers performed to facilitate the fetus passage through the vaginal canal. However, in addition, this concept extends to several other fields, which will be presented here.[27]

Brazilian obstetric care is still based on the technocratic hospital model, which centralizes the physician, as if he and the team were the commanders of the whole process in question, excluding female autonomy, and the woman is the protagonist, the active being of the delivery scene. That obstetric violence is not to be confused with procedures that can even generate physical harm or psychological trauma to those involved, but which are indispensable for the recovery of puerperal women and newborns, whose clear examples will be exposed to both sides: life-saving, can become a violent act, depending on the form and intention that the professional will use.[31]

Although there is no federal law deferring obstetric violence in Brazil, there are several public policies created in favor of female protagonism and reduction of tragic experiences, which ensure women's rights and that, if not respected, can hurt the Code of Ethics to be mandatorily followed by professionals who attend them, such as the Blind Network, through Ordinance No. 1459/2011, the Office of the Ministry of Health, among other projects that will be later

cited.[4]

The article will define the true obstetric violence, in which forms it is based on examples, which programs created to avoid it, the view of Nursing versus that of the population in the face of the theme, the damage that this violence can bring to the victim's body and mind, in order to collaborate for the production of quality studies for the academic society and draw more attention to this problem that is made so present in obstetric daily life, but at the same time, it is little addressed in practice.[20]

Method

The scientific research on the objects in this work is characterized as descriptive and, as for the procedures, as a bibliographic review. Moreover, the work will be presented through the discussion chapters, demonstrating the objectives and the bibliographic review.

The literature review was carried out using, as a source of research data, the Google Academic platform, where analyses were made in scientific articles published in estimated databases, such as SciELO, PubMed, Lilacs and BvSalud, with a qualitative approach, and with the aim of relating the data for the interpretation and perception of the reader to the severity of the problem-theme. The method used was the cross-sectional study, which addresses the definitive relationship between cause and effect of the phenomenon to be addressed.

We selected 62 articles for the development of the work, of which 34 were used. This study follows the standards of ABNT (Brazilian Association of Technical Standards) and guidelines of nip (Interdisciplinary Research Center) of the ICESP University Center.

Results and Discusssion

Having read the articles in full, the table below was elaborated with information related to the title, authors, year of publication, objectives and synthesis of results, articles from various sources.

Chart 1- Description of the articles included in the review. 2021**.**

Title	Author	Year	Objectives	Results Sinthesis
Physicians' perception of the dimensions of obstetric and/or institutional violence	Sems / Stamms	2019	Evaluate the perception of physicians who provide delivery care in a humanized public maternity hospital in southern Brazil on this theme	Institutional and/or obstetric violence is a phenomenon known and recognized in the perception of professionals who participated in this research, but still in the process of construction regarding its definition, categorization and denomination, being common the emergence of controversial aspects and divergence among those involved.

Knowledge about Law 11.108/2005 and the experience of companions with the woman in the obstetric center.	Frutuoso; Brugüemann	2013	To know what information the companions have about Law 11.108/2005, their perceptions about the experience in the obstetric center and the actions of support with women	Health professionals, involved in care during pregnancy, instruct women to choose who will accompany them during prepartum, childbirth and postpartum early and encourage their insertion whenever possible in prenatal care, providing guidance on the process of parturition and on their role as a support provider.
Nursing professionals' practices in the face of humanized childbirth	Andrade et al	2017	Know how humanization practices are developed during labor	It becomes of fundamental importance the preparation of the parturient for the proposal of humanized childbirth since prenatal care, with the use of humanized practices supported by the evidence Scientific.
Obstetric violence in the view of health professionals: the gender issue as a definer of childbirth care	Trajano; Barreto	2021	It discusses how health professionals (physicians and obstetric nurses, as well as residents of Medicine and Nursing in obstetrics) perceive the obstetric violence that women suffer in childbirth care, with the objective of analyzing obstetric violence described by the interviewees through the gender perspective.	Childbirth care should be based on the needs and interests of women as a subject of rights, understanding childbirth as a physiological process that integrates the female sexual experience. In a complementary way, the understanding of childbirth as a physiological, anthropological, social, psychological event, and not only as a medical act, underlies the idea that women should be the center of the process, by inversing a historically sedimented power relationship between patients and health professionals.
Factors associated with the occurrence of institutional obstetric violence: an integrative review of the literature	Souza et al	2016	Perform an integrative review of the literature on the factors associated with the occurrence of institutional obstetric violence and present the main evidencefound in the selected articles.	It was found that the professionals described as promoters of obstetric violence were physicians, nursing staff and medical students
Institutional violence in public maternity hospitals from the perspective of users	Aguiar; d' Oliveira	2011	Present and discuss the data of a research on institutional violence in public maternity hospitals, conducted in the city of São Paulo.	The interviewees report and recognize discriminatory practices and gross treatment in the context of care in public maternity hospitals, reacting with resistance strategies accommodation. These experiences occur with such frequency that many parturients already expect to suffer some kind of mistreatment, which reveals a trivialization of institutional violence.
Perception of obstetric nurses about obstetric	Leal et al	2018	To know the perception of obstetric nurses about obstetric	Some obstetricnurses do not recognize interventions as a violent practice. In addition, when such procedures are recognized as harmful practice, there is

violence			violence.	a justification of the help to the parturient to carry out the conducts

As medieval as it may seem, the brutality with which women are treated during labor is more present than is supposed; one in four Brazilian women suffers violence in childbirth according to a survey conducted in 2010 by the Perseu Abramo Foundation: "Brazilian Women and Gender in public and private spaces". Still in the 21st century, the process of birth is seen by many professionals as synonymous with savagery, suffering and medicalization, as if it lost its meaning if there were no such characteristics.[2]

Still in the present day, in which the biomedical model gives way to the holistic model of care, the parturient is treated as a passive being of her own delivery, as if her body were just a machine to be manipulated, without taking into account that she is a subjective being, who feels pain, fear, tiredness, dread, who has doubts and has rights, and this extends to legal issues.[8]

Many are unaware of obstetric violence and limit it only to physical damage caused by professionals who perform childbirth, as if it were performed crudely, which end up tearing some tissue of the woman. However, this aspect encompasses several fields besides the physical, as well as the psychic. Obstetric violence means any act performed by health professionals in that of the body, reproductive processes and psychological of women, expressed through dehumanized attention, abuse of interventional actions, medicalization and the pathological transformation of physiological parturition processes.[2]

In Brazil, unlike other countries, there is still no law that strictly legisle and punishes professionals who commit these violence, which harm and traumatize patients. However, these acts can be characterized in several criminal types, which are present in the Brazilian Penal Code, such as injury, ill-treatment, threat, illegal embarrassment, bodily injury, for example.[2]

There are several conflicts of ideas between health entities regarding the concept of obstetric violence, especially when it comes to the officialization of its use in daily life, which is the case in Brazil. Here, this term is widely used in the area of Health, but is still the subject of debates and criticisms, since certain bodies offer resistance to adopt it, and a clear example of this is Order No. 9087621, issued by the Ministry of Health on May 3, 2019, in which it declared itself in favor of the abolition of this, under the argument that there was no consensus regarding the definition of such a concept, and also that it is an inadequate expression, because it represents actions committed intentionally, which makes it inappropriate, due to the fact that professionals do not intend to cause purposeful harm to patients.[5]

This Order found support in Opinion No. 32/2018, of the Federal Council of Medicine, which suggested that violence against pregnant women should have another designation, because the proposal denigrates and disfavors medicine and the specialties of Gynecology and Obstetrics,[11] and was also supported by FEBRASGO - Brazilian Federation of Gynecology and Obstetrics Associations - which by note mentions that this expression aims to "demonize" the figure of the obstetrician, that obstetric care deficiencies have multifactorial causes, not only due to this specialist, but to all those involved in it.[15]

However, Recommendation No. 29/2019, made by the Federal Public Ministry (MPF) addressed to the Ministry of Health, highlights that the term "obstetric violence" is an expression already used in scientific, legal documents, and that its use is not abolished, but that measures are taken to suppress maltreatment practices.[22] In addition to this, the Federal Nursing Council (COFEN) supported this Recommendation elaborated by the MPF, recognizing that this expression needs to be adopted and debated, as this would be the first step towards reducing violence.[12]

Other institutions, such as the National Health Council (CNS), through Recommendation No. 24/2019,13 and the Brazilian Bar Association (OAB)[25] have spoken out against the extinction of terminology, and even the World Health Organization expressly recognizes the exacerbated occurrence of physical, verbal violence, disrespect and mistreatment in childbirth around the world, and that this is independent of the intentionality of the professional in causing harm, through the Declaration of Prevention and Elimination of Abuse, Disrespect and Maltreatment During Childbirth in Health Institutions, a document that focuses on the need to create more government programs that improve the quality of maternal health care, in addition to the importance of involving women in the fight for the eradication of abusive practices, emphasizing their rights to dignified assistance.[14]

Since obstetric violence can occur from various forms, it can be organized in types: One of them, physical abuse, has all the sudden acts, without necessity, performed on the woman's body, such as aggressions, nibbles, administration of medications not justified by the patient's condition, disrespect for the time of natural delivery without interference, iatrogenic procedures and which are not essential for the health of parturient son and fetuses.[14]

Among these procedures is the routine episiotomy, due to the team's haste not to wait for the physiological time of delivery. It is a surgical incision in the perineal region of the woman, which aims to prevent or decrease the trauma of the tissues of the birth canal, favor the release of the conceptus, avoid unnecessary lesions of the cephalic pole submitted to pressure suffered against the perineum or accelerate risk deliveries that, if time-consuming, can lead to morbidity and mortality.[14]

Another procedure is the Kristeller Maneuver, through which pressure is exerted on the upper part of the uterus, in order to make the baby leave faster, an action that can bring harm to both the mother and the baby, mentions the fracture of the mother's ribs and a brain trauma in the baby.[24]

In addition to these procedures, there is routine administration of synthetic oxytocin, a hormone indicated in cases of deliveries that do not follow as expected and need to be expedited and that, if not performed, would expose parturient and fetus to risks of complications and death.[33] There is also the denial of analgesia, which is the application of low doses of anesthesia, only to reduce the discomfort of women, but the muscle tone of LlLL is maintained;[19] the limitation of the position of the parturient, in which, according to medical reports, women who were forced to be in a limited position at the time of delivery, contrary to the scientific evidence and the patient's own protagonism. Unfortunately, according to the birth in Brazil survey in 2011, among the 23,940 postpartum women approached, 91.7% were in a lithotomy position in childbirth, which is the one that parturients are submitted to be more frequent ly

in terms of childbirth experiences.[18]

In another category is verbal abuse, which can be defined as any desecrated injury to the woman, through embarrassing phrases, offensive characterization, humiliating words, screams, expressions that put her under pressure, provide false or incomplete information to alienate her to accept iatrogenic interventions, all in order to prevent the woman from expressing her feelings during the delivery process.[29] Below, follows a picture of verbal offenses reported to several parturients, which are quite common in obstetric routine:

Chart 2 - Elaborated by the authors based on the experiences of women who reported their their stories of childbirth.

"At the time of doing not shout!"; " It was good time to do it, right? Now hold on!"; " Whoever entered now will have to leave!"; " If you keep yelling, I won't come and help you!"; Don't scream, or the baby goes up!"; " Be quiet, or it will hurt more!"; " Shouting is no use!"; It's good to do, but when it's time to get out, it's fresh."; " Stop being weak and push!"
"Your husband better not attend the birth, or he'll be disgusted with you!"; "We'd better have a c-section, because normal delivery scares through the vagina and so you can preserve your sexual relations and give more pleasure to your husband!"; "Look, your pelvis is too narrow, your baby wouldn't pass there... we will have to have a c-section!"; " Your baby hasn't turned, he's sitting, he's going to have to be a C-section."

Another category of abuse is psychological violence, which are actions that, in some way, harm the mental health of women, whether in pregnancy, childbirth or puerperium. The above-mentioned phrases are examples of these, and transmit fear and insecurity to the woman, because they exclude her autonomy and self-esteem. All these aspects directly influence the strengthening of the bond between the mother and her newborn, and due to trivial reasons, the woman feels frustrated, sad, disabled, and can transform this phase, which was to be of joy, in desolation, with risks of postpartum depression, aversion to the newborn, removal, traumas that can be perpetual.[30]

Institutional violence is also part of this list of abuses against women. This is the lack of adequate environmental structure to receive the patient, neonate and companion, whether in the pregnancy, delivery or puerperal period, and also includes the omission of care. Many patients do not have a proper bed, in some hospitals she and her NB are unable to bathe, companions have nowhere to even sit (some stand or sit on the floor for an entire night).[28] The table below highlights the problems mentioned.

Table 3 - Elaborated by the authors regarding the forms of institutional unpreparedness to receive women, companions and neonates, characterizing a type of obstetric violence.2021.

Physical structure	Lack of space and minimum comfort for accommodation of companions.
Equipment	Outdated delivery tables for humanized care, lack of basic

shortage	instruments and materials (e.g. broken beds, unscrewed leggings, etc.)
Ambience	Unaired environments, intense artificial lighting, lack of institutionalization of the Housing Set, lack of sheets, burnt showers, absence of seat for the companion, etc.
Administrative	Lack or non-compliance with obstetric protocols aimed at the humanization of care in the pregnancy-puerperal cycle; lack of periodic training of all employees engaged in care; sparse staff.

Obstetric violence, perceptibly, is not a strand practiced only by a specific professional class. Any subject involved in the care of women during the process of pregnancy, childbirth or puerperium, is subject to practice it, even without deed, and Nursing is an example. Some nurses, perhaps because of their time of experience and their older education, have greater resistance to interpret obstetric violence as something totally harmful and unethical, and that is likely to be avoided, due to archaic thoughts and procedures that are no longer suitable to the present day, hence the importance of continuing education, that is, the professional needs to seek constant updating of their knowledge.[32]

Each nurse has his/her perception about obstetric violence. Some refer this term to physical abuse related to contraindicated maneuvers performed in women; others refer to psychological abuse, with regard to the scumlike or lying phrases referred to them, just like the pressure to which they are subjected; others simply do not understand the procedures contraindicated as configuring agents of obstetric violence, given the thought that they are necessary for the progress of childbirth, and that they are doing them to help the parturient, not the other way around, even though they are aware that these are not beneficial to the mother-child binomial, according to scientific evidence.[20]

One of the reasons why obstetric violence occurs in such an incidence is the lack of knowledge on the part of the pregnant woman, especially about the rights she has, the laws and government programs that support her, and what she needs to be truly subjected to during the care provided to her in the pregnancy-puerperal period. Many trust in the actions of professionals, because of their wisdom, and it is from there that the second cause of obstetric violence is pointed out: professionals, because of technical-scientific training, are placed as the protagonists of childbirth, and the parturient as an adjunct, in which their autonomy to decide on what will be performed in their body is taken away, as well as their right to receive ethical and holistic care.[1]

With regard to the humanization of childbirth, it goes beyond conceiving in the comfort of a home inside a bathtub surrounded by family members and/or loved ones. It is to rescue human contact, to listen, to have a true welcome, to take away doubts, to clarify, explain, to create a bond with the client, to involve the family, not to exclude their right to have a companion during labor, is to see her as the protagonist of the process of parturition, not excluding the need to make present properly prepared professionals, qualified and responsible who commit themselves in the personal and professional sphere to receive the pregnant woman in a respectful way, considering ethics and dignity, leading her

to the stimulus she needs to externalize her freedom with regard to her active place in the parturition process, being the protagonist of this.[23]

In order to support pregnant women, legal precepts and programs were established. Law 9.263/1996, which guarantees access to prenatal care, which deals with family planning, is mentioned here, providing that women should have access to comprehensive health care, prenatal care and care for childbirth, the puerperium and the newborn through the Unified Health System - SUS. In addition, the Stork Network, Ordinance No. 1,459/GM, which seeks to reduce maternal and infant mortality rates, ensuring the sexual and reproductive advantages of women, men, young people and adolescents, bringing the systematization and institutionalization of a new model of birth care based on scientific evidence and the principles of humanization, which guarantees women the right to pregnancy, safe and humanized childbirth and puerperium beyond the right to reproductive planning and, for children, the right to birth, healthy growth and development.[10]

We also highlight the Program of Humanization in Prenatal and Birth, of the year 2000, which was created by the Ministry of Health, through Ordinance/GM No. 569, of 01/06/2000, to cause a reduction in maternal, peri and neonatal morbidity and mortality rates, implement actions aimed at ensuring the quality and improvement of access and coverage to prenatal care, delivery and postpartum care. It seeks to expand the measures already implemented by the Ministry of Health in relation to the care of pregnant women, such as the implementation of measures such as The Safe Maternity, Training Project of Traditional Midwives, outside the application of capital for the improvement and training of professionals who are already in this area of care, and finally the investment in hospital units that are part of these networks.[3]

There is also the Pact for the Reduction of Maternal and Neonatal Mortality – 2004, which refers to a group of strategic actions, together with governments, services and health professionals, also involving the whole society, and aims to ensure quality care to women and children in Brazil through strategies of health care, as for example, the stimulus for the participation of state and municipal health councils in the definition of contents and structuring of the National Pact; the articulation of co-responsible partnerships between different institutions; ensure the right of pregnant women to have a companion in prepartum, childbirth and immediate postpartum and joint accommodation; ensure that postpartum women and newborns do not have assistance denied in the services or spend a lot of time looking for them, among other strategies.[17]

Em adição a isso, tem-se a Portaria n° 1.683, de 12 de Julho de 2007, que foi nominada por Norma de Orientação para a Implantação do Método Canguru, um modelo de cuidado perinatal, desenvolvido com o intuito de prestar uma atenção de forma humanizada ao RN de baixo peso, que agrupa estratégias de intervenção bio-psico-social, onde os pais e/ou os familiares devem ser orientados e acompanhados, recebendo suporte pela equipe de saúde treinada.[6] Existe também a Lei nº 11.108, de 2005 (Lei do Acompanhante) e Portaria nº 2.418, de 2 de dezembro de 2005, que garante o direito a todas as parturientes que são usuárias do Sistema Único de Saúde - SUS, terem um acompanhante de sua escolha durante todo o processo do trabalho de parto, parto e pós parto, fazendo com que a paciente se sinta mais segura e reduzindo as chances de ocorrerem atos violentos.[7]

Other ordinances and partnerships are also considered, such as Ordinance No. 2068/2016 - Ministry of Health, which recognizes the need for improvements in the quality of care for women and newborns;[8] Ordinance No. 985/1999 - Ministry of Health, which created the Center for Normal Delivery (NPC), within the scope of the Unified Health System (SUS), for the care of women in the pregnancy-puerperal period;[9] Safe Maternity Project, created with the objective of increasing the quality of maternal and child care and reducing morbidity and mortality;[34] The Public Network's Normal Delivery Center, which has become a reference in the Federal District, a unit that provides obstetric and neonatal care, offering humanized reference service, with privacy differential that each patient has in their rooms, extended visiting hours, welcoming environment, guidance provided by the team (which is formed by obstetricnurses, nursing technicians, nutritionists and technicians in Nutrition - not counting doctors); and, finally, the Center for Normal Delivery of the Private Network, which provides assistance to pregnancy, childbirth and birth in a humanized way by the private network, the Light of Candeeiro Parto e Cuidado Feminino, located in the center of Brasília, in the neighborhood of Asa Sul, since 2012.[21]

Conclusion

In view of the above-mentioned facts, it was possible to understand that the concept of obstetric violence is much broader than society imagines, involving everything from physical and psychological aspects to the structural environment that the woman will receive and, intentionally or not, occurs in a dark reality, often unsettling. The present study was able to evaluate the so much damage that these abusive acts cause, causes the pregnant woman/parturient/postpartum woman to lose her autonomy at the moment it is hers, making her a passive being, adjunct, as a manipulated object, with no chance of reprimanding acts that bother her, which bring her suffering, fear, sadness, for fear of being harassed by professionals, who are the ones who should encourage it.

Moreover, it was analyzed that, due to the alienation that individuals have on the figure of the health worker, these violent acts are masquerading in the midst of routine, and become recurrent as if they were something common of care. Most put all their trust in the teams because of the scientific framework involved, so it creates the idea that the components are always doing what is right, and that the decisions they make must be compressed because it is the best thing to be made. It is interpreted that obstetric violence praises the professional and reduces the role of women, a step that only he is benefited, while the woman is totally harmed.

As emphasized, obstetric violence is a risk factor for fetal mortality, worrying world entities, and is increasingly focused on debates. However, with the literature review carried out, it is noticeable a restricted awareness of citizens regarding the concept of this aspect, in addition to various insecure interpretations, which makes evident the need for more research involving this theme, greater mass disclosures of its aspects, with clear language, in addition to more guidance on the rights of women as pregnant women, parturients and puerperal women, in order to create a critical sense in the population, avoiding violence. As demonstrated throughout this, Brazil even has government

programs and legislation aimed at improving obstetric care and implementing humanized care, however, we note that it is a necessity for the institutions to routinely supervise institutions, as these programs are not always obeyed in practice. It is also essential to create strict laws that realize the real concept of obstetric violence and punish those responsible for practicing it, as already occurs in several countries.

Another possible solution identified is the support to women psychologically harmed by obstetric violence, through programs that welcome them, with professionals who provide this type of care, because mental health should also be valued. It is also essential to improve the physical structure of hospital institutions, especially public ones, to offer greater comfort to users, as well as the construction of more Normal Delivery Centers, as they are a reference in humanized care in childbirth and postpartum.

Professionals are also involved in this search for the eradication of violence, and can contribute by seeking continuing education, that is, the constant updating of their knowledge, so as not to be concerned with obsolete methods of assistance and feel prepared to warn a colleague to do so. The nurse, as a health promoter, must honor his oath and provide the essence of his profession: to take care of the human being in a holistic way. It is the obligation of all involved to obey the recommendations and contraindications of health agencies, recognizing and respecting women's citizenship, preserving their entirety.

It is expected that the subjects addressed in this study can contribute to the perception of the importance of respectful obstetric care based on scientific evidence, and how harmful the lack of it can be. It is wished that it has become clear that interventions should be used only when there are true indications, allowing women to bring their children into the world with dignity and protagonism.

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The role of nursing in the face of palliative care in the intensive care unit

O papel da enfermagem frente aos cuidados paliativos na unidade de terapia intensiva

El papel de la enfermería frente a los cuidados paliativos en la unidad de cuidados intensivos

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RESUMO
Objetivo: Investigar como vem sendo o realizado o trabalho do enfermeiro frente aos cuidados paliativos no contexto da Unidade de Terapia Intensiva. **Método:** Revisão integrativa da literatura realizada no período de junho a agosto de 2021 Biblioteca Virtual da Saúde foi utilizada a base de dados Medical Literature Analysis and Retrieval System Online, Scientific Eletronic Library Online, Base de dados de Enfermagem e Manuais do Ministério da Saúde. **Resultados:** Foi realizado uma busca pelos descritores em saúde determinados e após análise sistemática dos artigos foram selecionadas 11 produções científicas que atenderam os critérios de inclusão. **Conclusão:** Portanto, podemos dizer que existe a necessidade do enfermeiro se aprofundar mais sobre a temática para que possa atuar com mais segurança, proximidade e implementar ações voltadas para as necessidades do paciente terminal e seus familiares.
Descritores: Cuidados Paliativos; Enfermagem; Unidade de Terapia Intensiva.

ABSTRACT
Objective:: To investigate how nurses' work has been performed in the context of the Intensive Care Unit. **Method:** Integrative review of the literature conducted from June to August 2021 virtual health library was used the database Medical Literature Analysis and Retrieval System Online, Scientific Electronic Library Online, Nursing database and Manuals of the Ministry of Health. **Results:** A search was performed for the defined health descriptors and after systematic analysis of the articles 11 scientific productions were selected that met the inclusion criteria. **Conclusion:** Therefore, we can say that there is a need for nurses to delve deeper into the theme so that they can act more safely, closely and implement actions focused on the needs of terminally ill patients and their families.
Descriptors: Palliative Care; Nursing; Intensive Care Unit.

RESUMEN
Objetivo: Investigar cómo se ha realizado el trabajo de las enfermeras en el contexto de la Unidad de Cuidados Intensivos. **Método:** Revisión integradora de la literatura realizada de junio a agosto de 2021 en la biblioteca virtual de salud se utilizó la base de datos Sistema de Análisis y Recuperación de Literatura Médica en Línea, Biblioteca Electrónica Científica en Línea, Base de datos de Enfermería y Manuales del Ministerio de Salud. **Resultados:** Se realizó una búsqueda de los descriptores de salud definidos y tras el análisis sistemático de los artículos se seleccionaron 11 producciones científicas que cumplieron con los criterios de inclusión. **Conclusión:** Por lo tanto, podemos decir que existe la necesidad de que las enfermeras profundicen en el tema para que puedan actuar de manera más segura, cercana e implementar acciones centradas en las necesidades de los pacientes con enfermedades terminales y sus familias.
Descriptores: Cuidados paliativos; Enfermería; Unidad de Cuidados Intensivos..

REVIEW

Introduction

The area of palliative care occurs as a therapeutic model that highlights views and therapeutic guidelines for the various symptoms responsible for physical, psychological, spiritual and social wear. It belongs to a growing area in which progress comprises several strategies that encompass bioethics, communication and the natures of suffering.[1]

However, palliative care provides quality of life for the patient when identification occurs as soon as possible, serving as a stimulus to the patient and their families who are facing a terminal illness. Prevention reduces the patient's suffering as long as there is an adequate assessment and treatment to relieve pain and other complications.

This care must be offered right from the start when the diagnosis of the disease that threatens the quality of life is discovered, and the therapies that will be used to treat the symptoms of the disease must be introduced. The relevance of the team's assistance requires a qualified approach, as the disease does not only lead to physical symptoms, but also to spiritual and psychosocial symptoms.

From these first fruits, this work came to expand academic knowledge and make palliative care aim to value and respect the terminal patient in order to highlight the role of nursing professionals in palliative care.

The desire to write about the topic arose through intensive care practice and the issues, obstacles and successful outcomes observed in the work of the intensive care team with the topic of Palliative Care (PC).

In this sense, the aim of the study was to investigate how nurses' work has been carried out in relation to palliative care in the context of the Intensive Care Unit.

Method

Integrative literature review carried out from August to September 2021. A systematic search of the literature published between January 2016 to September 2021 was carried out. The data search followed the procedures for reading titles, abstracts and full articles, to identify whether they contemplated the guiding question of this study.

The Medical Literature Analysis and Retrieval System Online (Medline), Scientific Electronic Library Online (SciELO), Nursing Database (BDENF), Manuals of the Ministry of Health were used through the Virtual Health Library (VHL). Due to being a new subject and with few studies focused on this theme, no other databases that could be used in that study were found. The following descriptors were used: "Nursing care", "Palliative care" and "ICU", separated by the Boolean operator "AND" in Portuguese and in English "Nursingcare", "PalliativeCare" and "ICU", such descriptors are registered in the DeCS (Health Science Descriptors) and/or MeSH (Medical SubjectHeadings). By searching the database, an initial result of 80 publications was obtained, which were filtered according to the inclusion and exclusion criteria, resulting in a number of 69, of which the duplicates and those that did not meet the proposed objective were excluded. in the research, therefore, eleven articles related to themes that make up the sample of this review were selected.

The eleven identified studies were organized in a table. To be included, the studies would have to meet the following criteria: Describe the participation of nurses in the application of palliative care, the knowledge mastered by the nurse and the

contributions of palliative care to patients in the Intensive Care Unit. Documents written in English and Spanish, available in full text and free of charge; publication date between January 2016 and September 2021. All studies that did not meet these criteria were excluded from the study. Finally, the studies were evaluated through content analysis**.**

Results and Discussion

It was observed that the eleven selected articles are related to palliative care understood as comprehensive care aimed at individuals in terminal conditions, with emphasis on the physical, psychosocial and spiritual aspects of the individual and family, in addition to its adoption by nursing in the Intensive Care Unit.

A search was carried out for the determined health descriptors and after systematic analysis of the articles, 11 scientific productions were selected that met the inclusion criteria, belonging to the Medline and Scielo database. Below is the table illustrating the selected sample:

Table 1 – Distribution of characterized articles, according to publication characterization: author/year, objective, title, result(s), conclusion. 2021.

Year	Objective	Title	Results	Conclusion
2019[2]	To verify the perception of the concept of Palliative Care from the perspective of health professionals working in an Intensive Care Unit (ICU)	Palliative care in intensive care: the perspective of the multidisciplinary team.	The study corroborates the literature on the limited perception of the PC concept by intensive care professionals, pointing out the need for training.	The study corroborates the literature on the often limited and outdated perception regarding the understanding of the concept of PC, as well as its practical implications. This fact points to the importance of investment, especially in relation to the training of the team, with an emphasis on promoting improvements in communication.
2016[3]	Describe palliative care in the context of the elderly population.	Palliative care	The aging process of the Brazilian population is increasingly accelerated and already poses deep, urgent and priority challenges for the country's public and social policy agenda, especially in the area of health.	The article refers to the importance of care being something to be shared not only by those working in health or in other areas of knowledge, but by society as a whole.
2019[4]	To investigate the team's knowledge about them and develop palliative care actions for patients with limited life support in intensive care.	Palliative care and life support limitation in intensive care	The results also characterize the timid position of professionals with regard to providing a dignified and suffering-free death for patients who die in the ICU with illnesses considered to be	Professionals recognized the importance of palliative care for the population in question in that unit. The study made it possible to bring together researchers and members of the multidisciplinary ICU team. Health professionals recognized the need to establish criteria to care for patients with limited life support in the ICU and the importance of palliative care, which can be applied through

			terminal. This finding requires the academy to plan new studies and the institutions to provide moments of analysis and reflection on the professionals' work process, with a closer look at palliative care for patients with limited life support.	systematized actions.
2020[5]	Raise the challenges that nursing faces to perform patient care in Palliative Care, based on the scientific production disseminated in online journals.	Challenges of nursing care in palliative care: an integrative review.	35 publications were identified, whose textual analyzes allowed the construction of four thematic approaches: Nursing education; Nursing care/assistance; Implementation of guidelines.	The study verified the gaps in nursing care in palliative care, raising the need for the development of new studies to disseminate knowledge on the subject..
2015[6]	Identify the structure of nurses' social representations about palliative care; discuss the repercussions of these representations in the daily care practice.	Social representation of nurses on palliative care	The central system is homogeneous, has a strong negative content and provides stability to the representation. On the other hand, the presence of positive elements in the peripheral system such as affection, comfort, dedication and humanization reinforce the flexible character of the representation.	Although palliative care and its technologies are increasingly present in hospital routine and, therefore, are the target of constant debates in the media, its social representation, elaborated by this group of nurses, remains with a strong negative content.
2016[7]	Knowing nurses' feelings about palliative care in adult intensive care units.	Palliative care and intensive care nurses: feelings that remain	The results showed how central ideas are related to feelings of comfort, frustration, insecurity and anguish, in addition to the feeling that training and professional performance are focused on	The nurses' social representations about feelings related to palliative care are mainly represented by negative feelings, probably consequent to the context in which the care is provided.

			dressing.	
2019[8].	Knowing the nurses' perception of cancer patients under palliative care	Nurses' perception of the meaning of palliative care in patients with terminal cancer.	The interpretive analysis of the interviews allowed the construction of three categories: Promotion of quality of life through the relief of pain and suffering; Palliative Care: a multiprofessional look at the terminal patient and family in the grieving process; Communication: source of dignity in the terminal process.	The study made it possible to evidence that the nurses involved recognize the importance of the multidisciplinary team, providing nurses with reflections on the use of communication as an essential element of care for patients and families under palliative care. E
2018[9]	Know the meaning of palliative care for the elderly for the nursing team and identify how the family's interactions with the elderly occur in the intensive care unit.	Palliative care for the elderly in intensive care: the nursing team's perspective	The results indicated three thematic categories: palliative care, with emphasis on pain and suffering relief; family and elderly interaction, highlighting communication as the most important; and inappropriate environment for palliative care, with an emphasis on care orientation	As the study showed, the team is knowledgeable about palliative care and recognizes the family as a link between the professional and the elderly. It is also considered that intensive care is not an appropriate environment for palliative care.
2016[10]	identify whether the concept and principles of Palliative Care defined by the World Health Organization are inserted in the work of nurses in Medical Clinic Units and in the Palliative Care and Pain Control Committee of a Teaching Hospital in the South of Brazil	Palliative care: view of nurses in a teaching hospital	Nurses link Palliative Care with the patient's death process. Limited communication obliterates the actions taken by team members. People with chronic disease are referred late, undergoing reductionist actions that do not provide quality of life	The principles of the philosophy of Palliative Care are partially inserted in the professionals' practice. There is demand for academic and in-service training.

2017[11]	Understanding the perception of the Nursing team about palliative care for patients in state ends	Palliative care in an intensive care unit: perceptions of nursing professionals	After exploring the data, three categories were found: The perception and experience of the Nursing team regarding palliative care. How palliative care is applied and Acting with the family in coping with the terminal state.	Palliative care is still little known and integrated into the actions of Nursing in the Intensive Care Unit, requiring greater team preparation.
2019[12]	discuss palliative care as a right to be guaranteed to the terminally ill, who, by recognizing the finitude of life, seeks physical, mental and spiritual comfort in their final moments.	The importance of implementing palliative care in the Unified Health System.	Population aging and the increase in non-communicable chronic diseases are demanding that medicine turn its attention to the patient, and not just the disease, encouraging rethinking about the process of dying and encouraging the patient to reappropriate his own death. A	The resignification of death and the dying process is today a necessary element to guarantee the patient's autonomy over his own body. Hence the importance of Resolution n. 41/2018 for the Brazilian Unified Health System.

In view of the analyzes and readings of the selected articles, with regard to palliative care, it is mentioned[7] that palliative care objectively addresses the improvement of the quality of life of patients and their families in the face of a life-threatening disease, due to means of prevention, relief of suffering, early identification, assessment, treatment of pain and other physical, psychological and spiritual problems.

They describe that applying palliative care consists, among other things, in providing basic care to the patient, such as nutrition, hydration, hygiene, comfort and pain relief. In addition to always maintaining a dialogue, even if the patient is unconscious and, whenever possible, meeting their personal desires and needs.[3]

In addition, palliative care can provide an opportunity to transform issues related to death, making it much more humanized. These precautions are not intended to interfere with the time that the transition may take place, but are based on supporting the family in the grieving process. Always seeking in a coherent way to offer the patient relief and reduction of suffering, both emotional and physical, improving the quality of life and generating a possibility of support until the last days of life[4].

Thus, strengthening the position of the aforementioned authors, it is emphasized that the focus of attention will not be the disease to be cured or controlled, but the individual, understood as an active being, with the right to information and with autonomy, when possible, to decide about your treatment5. In this sense, the

desirable practice of palliative care takes into account the particular attention to the patient and their family, aiming for excellence in care and prevention of suffering.

It is admissible to show that in the performance of palliative care, which health professionals perform, it is necessary to demonstrate certain skills such as understanding the importance of the care being provided, and that it is a privilege for these professionals to promote the welcoming of patients and families . Likewise, welcoming presents itself as a way to relate and perceive the most lasting sensitivity in the correlation with patients.[5]

It is reinforced that it is essential to take into account that the patient has the right to have all the information about the circumstance in which he finds himself. Respect for human dignity also reflects, if the patient does not want to know about their condition or treatment, equally, it is also their right.[10]

Thus, it is pointed out that the origin of the term palliative care is actually located in a discussion of medical practice about dealing with patients considered terminal. In this way, palliative care differs from curative care due to the medical notion of a "terminal" patient or "out of therapeutic possibilities.[5]

It is corroborated by emphasizing that palliative care has as its main focus the care, therefore it has some important principles such as: listening to the patient, making a diagnosis before treating, knowing very well the drugs to be used, using drugs that have more than one purpose of relief, proposing treatments as simple as possible, not treating everything that is affected by pain with medication and analgesics.[12]

It is evident that palliative care is intensive care and aims to learn to recognize, enjoy small achievements and be aware that there is always something that can be done here, without there being an end point.[9]

Other important principles in palliative care are added, such as: compassion, humility and honesty. It is necessary to have compassion, and empathy, because putting yourself in the other's shoes is the best way to do yourself good. The focus of care for the terminal patient is to help the person to "die well" alleviating their signs and symptoms with comfort and dignity. Nurses must be worked from the academy to deal with situations where being humble is an essential quality, as it is necessary to admit that they do not have all the answers and seek care on the issue. [5]

The health professional's emotional and physical strain is often apparent, as dealing with death, which is a stage of life where no one can avoid causing different feelings for nurses, but attention must be paid to the terminally ill person's family member, as he/she plays an important role and its reactions contribute to the patient's response. Taking care of the terminally ill family is an act of solidarity linked to knowledge and skill. And being honest with these people is a way to show love for others, since these days human beings are often acting mechanically without thinking about feelings. Nurses must use their creativity to sit down and talk to the patient about what is happening, giving them confidence and serenity.[8]

Os estudos demonstram que os cuidados paliativos são necessários devido às muitas doenças, que já não respondem aos tratamentos curativos, mas que causam intensa dor e sofrimento emocional e espiritual, e que tornam a vida insuportável. Com isso, é possível sempre estarmos presente como pessoa, oferecendo apoio e compreensão, conversando e ouvindo, tentando juntos encontrar alguma maneira de fazer com que as coisas sejam melhores, e assim, proporcionar uma melhor qualidade de vida.[4]

As for the patient's adaptation process to palliative care, it will depend on age; the stage of family development; the nature of the disease; from previous, individual and family experience; in relation to illness and death; the pattern of coping with stressful situations, the socioeconomic conditions and the cultural variables involved .[4]

Discussing palliative care and end-of-life issues is never easy, as these topics have not been learned nor discussed in our society. It is necessary to change the concept that nothing more can be done for the sick and, consequently, change their attitude. Thus, it is necessary to create committees to train health professionals, ensure the availability of drugs in palliative care units and create laws to protect doctors, patients and families.

Comenta-se que os governos precisam reconhecer e confiar de que os cuidados paliativos são essenciais e que devem ser incluídos nas políticas e nos serviços de saúde, de modo que as comunidades se tornem beneficiárias desses procedimentos. Para a enfermagem conceder cuidados paliativos é vivenciar e distribuir, terapeuticamente, ciclos de amor e compaixão, percebendo que é possível tornar a morte.[8]

It is assured that in palliative care there is a great effort together with the numerous health professionals, each one in their area, all with the same purpose, which is to alleviate and comfort the suffering of the patient and help their family. The nurse must integrate the practices not only related to the patient, but also to the family member/caregiver, perceiving the problems faced by them, so that they can idealize the situation in a systemic context, improving all instances: physical, social, cultural, spiritual and morals.[11]

Thus, the nurse is essential for the palliative care team, due to the foundation of its base, which is supported by the art of care. The seriousness of the category of this care is noticeable according to the birth of the ideology, emanating from the principle that this form of patient care promotes quality of life in their last days and also brings a feeling of accomplishment for the professional.[11]

Alleviating the experience of pain, sadness, fear and absences are something more that the nursing team can provide. The good relationship between patients, relatives and the nursing staff facilitates the structuring of therapeutic relationships that can ease the tension inherent to the condition, safeguarding the dignity and conceptions of the terminally ill patient. [11]

With this, it is argued that nursing specialists in palliative care must have ethical competence to understand and be responsible for the challenges that arise in the field of work. As a productive intention, it is essential that health professionals establish, in addition to technical-scientific efficiency, a human and ethical capacity, experiencing the true yields of bioethics for a good practice that is effective, understandable and respectful.[2]

The team that deals with palliative care seeks to be able to successfully develop its tasks, enabling the mental health of each member, fighting for it to be preserved and improved, since these achievements are important for the professionals themselves.[2]

Conclusion

The research leads us to conclude that palliative care provides a better quality of life in the terminal period of the patient, and should be extended to family members,

reducing the suffering of patients and family members, leading them to face and accept their condition as a natural process of finitude . Hence the need to be humanized and comprehensive and to be concerned with the patient and their needs and not just their diagnosis.

Thus, the role of nursing is important as it helps patients and families to accept their condition as a natural process of finitude. It was observed, however, that in the context of the ICU, we still find unprepared professionals who do not know the importance of palliative care and the need to involve social and affective aspects in the actions to be taken within palliative care. This unpreparedness can be caused by the lack of specific continuing education in palliative care, in addition to the review of initial training where little was focused on this issue. Thus, further studies, interventions and training are needed for professionals, thus seeking an improvement in the care system.

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Impact of the Covid-19 pandemic on the mental health of health professionals

Impacto da pandemia da Covid-19 na saúde mental dos profissionais de saúde

Impacto de la pandemia Covid-19 en la salud mental de los profesionales de la salud

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RESUMO

Objetivo: analisar as questões relacionadas à saúde mental dos profissionais de enfermagem durante a pandemia do Sars-Cov-2, identificando as principais doenças mentais acometidas e destacando a participação dos Programas Nacionais de Saúde para minimizar os impactos da pandemia sobre esses profissionais. **Método:** Trata-se de um estudo de revisão bibliográfica realizado nas bases de dados Pubmed, SciELO-Brasil e Biblioteca Virtual em Saúde nos anos de 2020 e 2021. **Resultados**: Foram selecionados dez artigos referentes ao tema e, após interpretação destes, notou-se um aumento de transtorno de ansiedade e depressão entre os profissionais, com impacto à sua saúde mental nesse cenário pandêmico devido a sua atuação na linha de frente. **Conclusão:** a saúde mental dos profissionais de enfermagem durante a pandemia parecer ter sido comprometida, com impacto potencial à qualidade da assistência ao paciente.
Descritores: Saúde mental; Pandemia; COVID-19; Enfermagem; Profissionais.

ABSTRACT

Objective: to analyze the issues related to the mental health of nursing professionals during the Sars-Cov-2 pandemic, identifying the main mental illnesses affected and highlighting the participation of national health programs to minimize the impacts of the pandemic on these professionals. **Method:** This is a bibliographic review study conducted in the Pubmed, SciELO-Brazil and Virtual Health Library databases in 2020 and 2021. **Results:** Ten articles on the theme were selected and, after interpreting these, an increase in anxiety and depression disorder was noticed among professionals, with an impact on their mental health in this pandemic scenario due to their performance on the front line. **Conclusion:** the mental health of nursing professionals during the pandemic seems to have been compromised, with a potential impact on the quality of patient care.
Descriptors: Mental health; Pandemic; COVID-19; Nursing; Professionals.

RESUMEN

Objetivo: analizar los temas relacionados con la salud mental de los profesionales de enfermería durante la pandemia de Sars-Cov-2, identificando las principales enfermedades mentales afectadas y destacando la participación de programas nacionales de salud para minimizar los impactos de la pandemia en estos profesionales**. Método:** Se trata de un estudio de revisión bibliográfica realizado en las bases de datos Pubmed, SciELO-Brasil y Biblioteca Virtual en Salud en 2020 y 2021**. Resultados:** Se seleccionaron diez artículos sobre el tema y, tras interpretarlos, se notó un aumento del trastorno de ansiedad y depresión entre los profesionales, con impacto en su salud mental en este escenario de pandemia debido a su desempeño en primera línea. **Conclusión:** la salud mental de los profesionales de enfermería durante la pandemia parece haberse visto comprometida, con un impacto potencial en la calidad de la atención al paciente.
Descriptores: Salud mental; Pandemia; COVID-19; Enfermería; Profesionales.

REVIEW

Introduction

Viruses have been around for a long time in nature, specifically in wild animals. Following the story line, with population growth and the proximity of man to wild animals, the viruses mutated until they managed to infect the human body and multiply.[1]

Thus, man's contact with wild animals has become increasingly favorable to the reproduction environment of viral diseases, resulting in the spread of transmissible diseases that affect the respiratory tract. Therefore, these evils were responsible for epidemics and pandemics throughout history.[2] An epidemic is defined as the advance of a certain disease in a delimited area in a short period; when these diseases affect different countries and different people, it is called a pandemic.[3]

In this context, the World Health Organization (WHO) reported the COVID-19 outbreak as the 6th Public Health Emergency of International Importance after H1N1 (2009); Poliomyelitis (2014); Ebola in West Africa (2014); Zika (2016) and Ebola in the Democratic Republic of Congo (2019); and, recently, COVID-19 (2020).[4]

Thus, it was possible to observe the contemporary scenario of world health caused by the new coronavirus, the generator of COVID-19 (Corona Virus Desease-19). Checking seven currently known coronavirus strains, including the Severe Acute Respiratory Syndrome Sars-Cov, Mers-Cov and Sars-Cov-2.[5]

It was first notified on December 31, 2019, in Wuhan City, Hubei Province, China. In Brazil, the Ministry of Health reported the first case on February 26, 2020, in the city of São Paulo. On March 11, 2020, the World Health Organization (WHO) declared a state of pandemic for COVID-19 and recommended social isolation.[6]

According to the WHO, 80% of cases are asymptomatic – without symptoms – or may be oligosymptomatic – few symptoms – and 20% require specialized hospital care. Its transmission occurs mainly through the respiratory tract and through the inhalation of droplets and/or aerosols. We can mention that the main symptoms of COVID-19 are: cough, fever, runny nose, sore throat, difficulty breathing, loss of smell (anosmia), change in taste (ageusia), gastrointestinal disturbances, tiredness (asthenia), decreased appetite (lack of appetite), shortness of breath (dyspnea), which can even cause severe pneumonia.[7]

According to the Ministry of Health, of the 601,574 deaths that occurred between 2020 and 2021 in Brazil, the Federal Council of Nursing - COFEN, 866 cases occurred with specialists in the field of nursing who were on the front line fighting COVID-19, such as: nurses, technicians, nursing assistants and midwives, representing 0.144% of obituaries.[7-8]

COFEN data show that there are 2,564,908 registered health professionals in Brazil. Comparing the global number with data from COFEN, the number of nursing professionals' victims of SARS-Cov-2 represents 426.366% of deaths and of nurses 104,799%.[9]

In general, the COVID-19 pandemic causes several damages, in addition to compromising health, it also affects socioeconomic variables. In the field of health professionals, specifically nursing professionals, who are responsible for performing highly complex procedures, for this, it requires a technique that

requires scientific knowledge and immediate decision-making, they are professionals who are at the bedside 24 hours a day, increasing the risk of contagion for both the health worker and third parties.[10]

As this is a virus in which its transmission takes place through droplets and/or aerosols, the use of personal protective equipment (PPE) is necessary. However, the precariousness, and even its lack, increases the insecurity and anguish of the nursing teams. Double shifts, or even triple shifts, as they are excessive, constantly exhausting hours, increase physical and psychological suffering.[10]

Given the above, the vulnerability of nursing professionals, in the face of the COVID-19 pandemic, can generate strain on their mental health.

Thus, the reflection remains: what is the direct relationship of the pandemic, the socioeconomic system and the stress suffered by health professionals and the prevention of their mental health?

Therefore, the aim of this study was to analyze the issues related to the mental health of nursing professionals during the Sars-Cov-2 pandemic, identifying the main mental illnesses affected and highlighting the participation of National Health Programs to minimize the impacts of the pandemic on these professionals.

Method

This is a bibliographical, descriptive and qualitative study, based on research of articles published in renowned journals, with the purpose of evaluating the worsening of the mental health status of the nursing teams, highlighting the diseases that stand out most for this reason of the COVID-19 pandemic, due to constant debates both in the social and professional environment and in the media.

In order to decide which studies would be included in this article, the means to be followed to identify relevant issues, as well as the data to be taken from each selected subject, we established the development of a guiding question, which is considered the most important part of the literature review. Thus, the following question was obtained: what is the direct relationship between the pandemic, the socioeconomic system and the stress suffered by health professionals and the prevention of their mental health?

Data were collected using the following tools: Pubmed, SciELO-Brasil, BVS, COFEN, Ministry of Health and World Health Organization, using the following descriptors: “mental health”, “pandemic”, “COVID-19” , “nursing” and “professionals”. The documented materials, as well as the respective analyses, were organized in reports that make up the present study.

In the construction of this article, the following inclusion and exclusion criteria were used, and articles whose full texts were accessible, in Portuguese and English, in the period from 2020 to 2021, were evaluated. 2020, in languages other than Portuguese and English, which are not related to the study in progress, it was preferred not to include theses, dissertations and monographs.

With the parameters used, 14 articles were found in the Pubmed database, 11 articles in the Scielo-Brasil database, 127 articles in the VHL database, totaling 152. The articles analyzed that performed the specifications with the criteria of inclusion were 52 articles reached and studied in full.

Continuously, systematic readings were performed and only ten articles met the inclusion criteria.

Results and Discussion

Overview of selected articles

Ten articles were identified in this integrative review, interpreted and reduced by comparing the data exposed in the investigation of the theoretical framework, according to chart 1.

The study method was based on research, in which scientific articles corresponded to 10% - descriptive, quantitative and retrospective cross-sectional study; 10% - narrative review; 10% - cross-sectional and descriptive study; 10% - sectional study; 10% - technical-scientific literature review; 30% - reflection studies; and 20% exploratory analysis articles, descriptive of a quantitative approach.

Since, among the articles included in this literature review: three address Burnout Syndrome; six, depression; seven, anxiety; nine, occupational stress; one, post-traumatic disorder – PTSD; one, obsessive compulsive disorder - OCD.

Chart 1- Distributions of articles found from database searches, according to the name of the authors, article, journal, year of publication and its purpose. 2021

N	YEAR	TITLE	JOURNAL	AUTHORS	OBJECTIVE
1	2020	The Impact of Covid19 on the Work of Brazilian Nursing: Epidemiological Aspects	Focused Nursing	Nascimento VF. Espinosa MM. Silva MCN. Freire NP. Trette ACPT	To analyze epidemiological aspects of COVID-19 infection in nursing professionals during the emergence of the pandemic in Brazilian territory in 2020
2	2020	Repercussions of COVID-19 on the Mental Health of Nursing Workes	Journal of Nursing of the Midwest of Minas Gerais	Luz EMF, Munhoz OL, Morais BX	Reflect on the repercussions of COVID-19 on the health of nursing workers.
3	2020	Psychosocial Support and Mental Health for Workers Nursing	Focused Nursing	Moreira AS, Lucca SR	Describe and discuss the performance of nursing professionals, their exposure to risk factors at work and the importance of psychosocial support in the COVID-19 pandemic.
4	2020	Tolerance Levels in Friendship Relationships of Health Professionals During the COVID-19 Pandemic	Revisa	Silva RM, Moraes- Filho IM, Valóta IAC, Saura APNS, Costa ALS, Sousa TV, Carvalho-Filha FSS, Carvalho CR.	To analyze the level of tolerance in friendly relationships among health professionals during the COVID-19 pandemic

5	2021	Depression and Anxiety in Nursing Professionals During the COVID-19 Pandemic	Anna Nery School	Santos KMR, Galvão MHR. Gomes SM. Souza, TA. Medeiros, Arthur, A. Barbosa, IR	To analyze the prevalence of symptoms of depression, anxiety and associated factors in Arthur's nursing staff during the COVID-19 pandemic
6	2021	Strategic Empathic Listening to Welcoming Nursing Professionals in Confronting the Coronavirus Pandemic	Reben	Tobase L, Cardoso SH, Rodrigues RTF, Peres HHC	Reflect on the use of empathic listening as a strategy for welcoming nursing professionals in facing the challenges during the coronavirus pandemic.
7	2020	Nursing in the Times of COVID-19 in Brazil: a look at the Management of the Work	Focused Nursing	Machado MH	To analyze the situation of the nursing team in the context of the pandemic in Brazil, focusing on the management of the work of these professionals.
8	2020	Mortality of Nursing Professionals by COVID-19 in 2020: Brazil, United States, Spain and Italy	Revisa	Benito LAO, Palmeiras AML, Karnikowski MGO, Silva ICR	To analyze the mortality of nursing professionals (NP) by COVID-19 in Brazil (BRA), United States (EUS), Spain (ESP) and Italy (ITA) in the first half of 2020.
9	2020	Mortality of Nursing Professionals by COVID-19 in 2020	Revisa	Benito LAO, Palmeiras AML, Karnikowski MGO, Silva ICR	To analyze the mortality of nursing professionals (NP) by COVID-19 in the first half of 2020.
10	2020	Mental Health and Interventions Psychological in the face of Coronavirus Pandemic (COVID-19)	Campinas Psychology Study	Schmidt B, Crepaldi MA, Bolze SDA, Neiva-Silva L, Demenech LM	Systematize knowledge about implications for mental health and psychological interventions in the face of the new coronavirus pandemic

Impact of the COVID-19 pandemic on the mental health of health professionals

The COVID-19 pandemic gave visibility to health professionals (HP), especially the nursing staff. The year 2020 was considered by the WHO as the "International Year of Nurses and Midwives", due to the 200 years of Florence Nightingale, which was marked by a pandemic.[11]

When comparing the circumstances of COVID-19 with other pandemics, we note that this is a serious phase that the world is experiencing. As a result, the need for highly complex care to meet all those affected by this disease increased. Taking care of human needs is a function of nursing. As the largest category within hospitals, they gained greater recognition and responsibility during the pandemic.[12]

Under the circumstances of COVID-19, workers underwent sudden changes in their work routine, whether public or private, having to adapt to new demands and work demands. The resizing and restructuring of human and material resources, elaboration and implementation of protocols, among others. Health professionals are under pressure to develop productivity and results, along with the risk of virus infection.[12]

Therefore, nursing, in addition to suffering from the overload of hours worked, lack of resources and devaluation, there is still bullying, as 90% of nursing professionals are women. It is noteworthy that there is still a culture that the woman is responsible for the housework related to the monitoring of children, marriage and the home. These factors corroborate the emergence of disorders.[13]

Because they are professionals who are in direct contact with patients in a state of suffering and because they are facing the pandemic, the high risks of mental illness are intensified. Work overload, devaluation, lack of personal protective equipment - PPE, unhealthy working conditions, social distance, the large number of contaminated professionals and the fear of contagion contribute to physical and psychological exhaustion.[14]

Due to unhealthy conditions and the lack of adequate equipment, the Federal Council of Nursing (COFEN) has carried out inspections to verify working conditions and PPEs, where there is a considerable number of shortages of professionals on leave, which can trigger a collapse in the Health System. Health.[15]

Professionals who are daily exposed to traumatic and challenging situations, developing mental disorders - generalized anxiety, depression, sleep disorders, obsessive-compulsive disorder (OCD), Burnout syndrome (professional exhaustion), post-traumatic stress disorder (PTSD) – which can thus lead to suicide.[13,16]

Nursing professionals have a greater tendency to develop some mental disorder, depression being one of the three main ones. Lack of recognition and stress at work are factors that contribute to this diagnosis.[15]

Still in this perspective, depression and anxiety are the factors that most affect nursing professionals. Such phenomena are linked to the work routine, since, at the present time, many people are lost and these professionals end up being emotionally affected, given the drama of families and even their relatives. Allied to this, there is an excess of demand on the part of society, which is in

panic and despair. Also, this labor crisis corroborates the demands of the public power, which, for the most part, does not provide adequate resources for the least amount of assistance possible[15].

As it has become a problem with great worldwide demand for mental health care, in some countries there is a classification of psychological vulnerability, which placed health professionals and infected people in social isolation as priorities for receiving psychological care.[13]

Thus, the emotional wear of the nursing professional, when treating a patient with COVID-19, for being in isolation from the physical contact of their family members during hospitalization, and when a sedation/intubation procedure has to be performed, a bond of care and affection with the sick.[17]

Comprehensive patient care has generated work overload for nursing professionals, as they spend more time and have direct contact with infected patients. Allied to this, there is the exposure of biological materials, invasive procedures, vulnerability to contamination, aggravating the emotional state, which may lead to idealization of suicide.[18]

In Brazil, for better management, the "COVID-19 Crisis Committee" and the "Nursing Observatory" were created by the COREN/COFEN committee in May 2020, where data on professionals infected with the coronavirus are registered. , informed by the health service. There were 58,845 reported cases and 89 deaths.[19]

COFEN, in conjunction with the National Committee on Mental Health Nursing, has offered virtual assistance to nursing professionals who work on the front lines during the pandemic, carried out 24 hours a day, seven days a week, allowing five nurses to provide assistance simultaneous.[15]

In order to offer support to health professionals who are on the "front line" against COVID-19, the Ministry of Health published, on March 31, 2020, Ordinance No. 639, which provides for strategic action, a program entitled "Brazil counts on me Health Professionals", with the purpose of reducing the stress of health workers. This program aims to reduce the impact that the pandemic has had on health professionals, specifically the damage to mental health and also prevention, in order to better deal with the psychological pressure in the management of patients.[20]

Conclusion

Therefore, with the pandemic scenario, there were not only physical health problems, but also emotional and mental health problems, with the fear of contagion and transmission of the virus as determining factor. In addition to being at risk, they have their personal, professional, family and friends lives, which creates more concern.

Regarding the form of transmission and prevention of contamination between health professionals and society, it led to an increase in the shortage of employees, even causing deaths. This scenario caused in the referred professionals: chronic stress, physical and mental exhaustion, contributing to the aggravation and increase of psychosomatic and mental illnesses.

In summary, it can be asserted that the pandemic showed the importance of health professionals for the general population, especially nursing teams, as they are the first to have contact with patients infected by Sars-Cov-2.

With the described scenario, a greater technical-scientific value is expected, a proportional increase in the number of nursing staff, a review of the working hours, as well as improvements in their conditions and the expansion of support programs for the prevention of mental health.

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Covid-19 pandemic repercussions for adolescents in social vulnerability

Repercussões da pandemia da Covid-19 para adolescentes em vulnerabilidade social

Repercusiones de la pandemia del Covid-19 para adolescentes socialmente vulnerables

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RESUMO

Objetivo: Refletir sobre as repercussões da pandemia da COVID-19 para adolescentes em vulnerabilidade social. **Método:** Trata-se de um artigo de reflexão fundamentado em revisão bibliográfica. Para subsidiar essa reflexão, foram realizadas leituras e análise de publicações entre os meses de abril de 2020 a setembro de 2021. **Resultados:** As condições de vida e saúde vivenciadas por adolescentes em vulnerabilidade social se intensificou durante a pandemia da COVID-19 o que pode acarretar prejuízos físicos e mentais para esse grupo. **Conclusão:** Se fazem necessárias políticas com direcionamentos interseccionais que atentem para as necessidades de saúde de adolescentes compreendendo as subjetividades e especificidades desse grupo.

Descritores: Adolescente; Vulnerabilidade Social; Infecções por Coronavirus.

ABSTRACT

Objective: Reflect on the repercussions of the COVID-19 pandemic for socially vulnerable adolescents. **Method:** This is an article for reflection based on a literature review. To support this reflection, readings and analysis of publications were carried out between the months of April 2020 and September 2021. **Results:** The living and health conditions experienced by adolescents in social vulnerability intensified during the COVID-19 pandemic which can lead to physical and mental damage for this group. **Conclusion:** Policies are needed with intersectional directions that address the health needs of adolescents, understanding the subjectivities and specificities of this group.

Descriptors: Adolescent; Social Vulnerability; Coronavirus Infections.

RESUMEN

Objetivo: Reflexionar sobre las repercusiones de la pandemia COVID-19 para los adolescentes socialmente vulnerables. **Método:** Este es un artículo de reflexión basado en revisión de la literatura. Para sustentar esta reflexión, se realizaron lecturas y análisis de publicaciones entre los meses de abril de 2020 y septiembre de 2021. **Resultados:** Las condiciones de vida y de salud que experimentan los adolescentes en vulnerabilidad social se intensificaron durante la pandemia de COVID 19 que pueden derivar en daños físicos y psíquicos. para este grupo. **Conclusión:** Se necesitan políticas con direcciones interseccionales que aborden las necesidades de salud de los adolescentes, entendiendo las subjetividades y especificidades de este grupo.

Descriptores: Adolescente; Vulnerabilidad social; Infecciones por coronavirus.

Introduction

The current scenario, resulting from the pandemic of the new coronavirus, has had physical, social, emotional and financial repercussions on the population, besides exposing how much social inequalities influence the ways of coping with COVID-19. Since the beginning of March 2020, when the World Health Organization (WHO) decreed the pandemic, global society has suffered the impacts of the high potential for virus infection.[1] The developments caused by the new coronavirus have generated unprecedented impacts on the entire nation, however, they have not presented themselves in an equitable way for all ages and population strata. Elderly people, individuals with chronic diseases are the group at high risk of developing the most severe form of the disease and the population groups that are exposed in environments with agglomerations are exposed to the highest probability of contracting the virus.[1]

In Brazil, the black population represents 54.9% of Brazilians, the most affected by social inequalities such as unemployment, inadequate housing conditions, low income and lower level of education.[2] In this population, adolescents who experience physical, psychological, social changes, typical of development and may be affected by the repercussions of the COVID-19 pandemic stand out.

Although adolescents have a lower prevalence for complications related to COVID-19, it is perceived that the challenges imposed by the social context may bring significant repercussions for this group. In the face of the above, the question is: How can the pandemic developments of the new coronavirus have repercussions for adolescents inserted in contexts of social vulnerabilities? In view of these considerations, this manuscript aims to reflect on the repercussions of the COVID-19 pandemic for adolescents in social vulnerability.

Method

It is an article of reflection based on a bibliographic review of scientific, journalistic productions, and information made available by the World Health Organization, The United Nations, oswaldo cruz foundation and the Brazilian Institute of Geography and Statistics.

This study aimed to analyze the repercussions of the COVID-19 pandemic for adolescents in social vulnerability. To support this reflection, readings and analysis of publications were carried out between April 2020 and September 2021.

Results and Discussion

Adolescents in social vulnerability during the Pandemic

Adolescence should not be understood only in the physiological and/or temporal perspective, but by its intersections between biopsychosocial factors that directly reflect on the quality of life of the human being. Thus, the COVID-

19 pandemic intensely reveals how social differences can have serious repercussions for this age group.

Social vulnerabilities are understood as inadequacies or differences that are experienced by a group and negatively results in the access and availability of material resources and/or opportunities such as education, work, health, income, leisure and culture.[3-4]

The housing conditions of adolescents in social vulnerability reflect the reality of families who survive on minimum incomes, mostly have low levels of education and these disparities tend to reflect their quality of life. Unemployment rates rise globally, increasing the financial difficulties that compromise the acquisition of key amounts for survival.[5] In the first four months of the Covid-19 pandemic in Brazil, the unemployment rate rose from 12.4% to 13.1%, reaching 12.3 million people.[6]

The financial conditions and low income of families can cause repercussions for adolescents such as susceptibility to physical, verbal and/or sexual violence, difficulties in entering universities and the labor market, exposure to diseases and early pregnancy. Realities faced mainly by black adolescents in Latin America that can be enhanced during the pandemic.[7]

With the advent of the covid-19 pandemic, students in conditions of social vulnerability, for the most part, are having losses in their schooling process. Above all, due to the long period without classes, the difficulty of access to technological resources, and because they reside in environments not favorable to the modality of distance learning.[8] This reality has caused deficits in the learning process and in the long run can corroborate to accentuate the difficulties already existing, especially with the access to higher education, constituting another obstacle that limit the process of social mobility of this population.

In addition to educational repercussions, idleness, stress, anxiety, possible domestic conflicts, deprivation of leisure and sports activities are conditions that can cause physical and mental damage. The intensification of living in homes has accentuated the existing burdens and weaknesses, exposing the adolescent to multiple violence within the domestic space itself.[9] Associated with these factors, it is highlighted that the use of masks in public spaces by black adolescents triggered feelings of insecurity, fear and longing to be exposed to discrimination and violence.[10] This uncertain and unsafe context may corroborate the severe mental illness.[11]

With the pandemic, the spaces of psychological, social, leisure, security and protection support of these adolescents such as schools, community centers, non-governmental institutions for social, interactive and religious practices were closed, making it impossible for these adolescents to be close to their main support networks.

In view of this reflection, it is necessary to implement urgent actions that seek to offer an improvement in the health of the adolescent population within its biological, psychological and social dimensions. It is important to emphasize that the vulnerability that this group is immersed in, is directly linked to the existence of racism and an action to be implemented must be the fight against this structural oppression.

Conclusion

Adolescence is considered a decisive phase for the process of human construction. Social inequalities are more incisive in the pandemic period and tend to corroborate that adolescents in social vulnerability remain in social invisibility. Moreover, policies with intersectional directions are needed that affect the health needs of adolescents, understanding the subjectivities and specificities of this group.

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Experience of Women Who Had Natural Childbirth

Experiência de Mulheres que Tiveram Parto Natural

Experiencia de Mujeres que Tuvieron Parto Natural

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RESUMO

Objetivo: descrever a experiência de mulheres que tiveram vivências negativas e passaram pelo parto natural, a partir de uma página virtual na rede social Instagram. Tendo como problema de pesquisa: De que maneira as experiências negativas no parto natural podem influenciar na escolha da via de parto e seus benefícios posteriormente? **Método:** abordagem qualitativa e método de história oral. **Resultados:** Foram entrevistadas de 05 participantes com idade entre 22 a 53 anos, com diferentes graus de escolaridade que vivenciaram algum tipo de experiência negativa no parto natural. **Conclusão:** A coleta de dados evidenciou que há muito ainda a se fazer no atendimento à gestante, seja por parte da enfermagem ou equipe multiprofissional. Que a humanização tão descrita e comentada por muitos precisa ser melhor aplicada e constantemente avaliada para que a assistência seja de fato integral.

Descritores: Saúde Parto; Assistência Integral à Saúde das Mulheres; Parto normal.

ABSTRACT

Objective: to describe the experience of women who had negative experiences and went through natural childbirth, from a virtual page on the social network Instagram. Having as a research problem: How can negative experiences in natural childbirth influence the choice of delivery method and its benefits later on? **Method:** qualitative approach and oral history method. **Results:** Five participants aged between 22 and 53 years old, with different levels of education, who had some kind of negative experience in natural childbirth, were interviewed. **Conclusion:** Data collection showed that there is still much to be done in the care of pregnant women, whether by the nursing staff or the multidisciplinary team. That the humanization so described and commented on by many needs to be better applied and constantly evaluated so that care is truly comprehensive.

Descriptors: Parturition; Comprehensive Assistance to Women's Health; Natural Childbirth.

RESUMEN

Objetivo: describir la experiencia de mujeres que tuvieron experiencias negativas y pasaron por un parto natural, a partir de una página virtual en la red social Instagram. Teniendo como problema de investigación: ¿Cómo pueden las experiencias negativas en el parto natural influir en la elección del método de parto y sus beneficios posteriores? **Método:** enfoque cualitativo y método de historia oral. **Resultados:** Se entrevistaron cinco participantes con edades entre 22 y 53 años, con diferentes niveles de escolaridad, que tuvieron algún tipo de experiencia negativa en el parto natural. **Conclusión:** La recolección de datos mostró que aún queda mucho por hacer en el cuidado de la mujer embarazada, ya sea por parte del personal de enfermería o del equipo multidisciplinario. Que la humanización tan descrita y comentada por muchos necesita ser mejor aplicada y constantemente evaluada para que la atención sea verdaderamente integral.

Descriptores: Parto; Asistencia integral à la salud de la mujer; Parto normal.

ORIGINAL

Introduction

Natural childbirth is the oldest known form of childbirth worldwide. In the early days, midwives provided assistance to women and newborns at home. The instability of the care provided led, many times, to infections and postpartum hemorrhages that could result in the death of the woman. The improvement of medicine in care from the pregnancy cycle to the puerperal brought significant improvement in the face of maternal and infant mortality. Childbirth ceases to be physiological and becomes an event with interventions, be it drug or surgical.[1]

Cesarean sections in Brazil have reached high annual rates. A cesarean section should be performed by justified clinical indication, but this number is due to obstetric clinics and even preference of health professionals or women. When such a procedure is justified it brings health benefits and decreases the number of morbidities.[2]

The choice of cesarean delivery by the woman can happen due to the influence of family, friends, unpleasant experiences in previous delivery and statements found in the media. Cesarean Section is exposed as a safer way and without the pain provided by natural childbirth. This choice may also be associated with family income that can guarantee the choice of the type of delivery in private networks.[3]

Most pregnant women already acquire fear regarding vaginal delivery associated with reports of people close to their trust, who may have experienced some complication or undergone some intervention or mistreatment during their previous experiences. These reports may cause a change of heart about the benefits of vaginal delivery and may cause anxiety and fear in women, who fear that the same will occur in childbirth. The provision of information and the withdrawal of doubts of pregnant women during prenatal care is important, as it can unmask fears and fears related to their moment.[3]

Normal delivery is related to high levels of satisfaction without increasing the risk to mother and baby. This mode of delivery provides a faster recovery for the woman, lower risk of infection, recovery of the uterus more quickly, besides providing greater activity for the baby and greater immediate contact with the mother.[4]

Therefore, it is important for professionals involved in prenatal care to the puerperium to provide information to women about the advantages and benefits of choosing natural delivery. They should also provide a calm environment and support women in their rights and choices, providing their role as the main person of this moment. This study presents the following problem: How can negative experiences in natural childbirth influence the choice of the route of delivery and its benefits later?

The aim of this study was to describe the negative experiences experienced in natural childbirth by women who are members of a profile called "Waiting for a delivery" on the Social Network of Instagram.

The study becomes relevant because it may present data to the awareness that the poor experience experienced by women in natural childbirth can affect their choice in a cesarean delivery later, not taking into account its benefits for the pregnant woman and the fetus.

It may reveal the importance and development of workers in the area of obstetrics and professionals in training in humanized care provided to women in prenatal, childbirth and postpartum.

It can contribute to a new look at humanized care in the area of obstetrics, so that at this moment when the woman is the protagonist she can experience this stage of her life in the best possible way by untying the natural birth of a moment of only suffering and bad experiences. Finally, it may stimulate further research in the area of women's health.

Methodology

The methodology for this study was a qualitative approach and oral history method following the assumptions of Halbwachs.[5]

Data were collected through a virtual meeting by Zoom Cloud Meetings, where the recording was performed and later, transcription for analysis of the data obtained. It was collected as a questionnaire of 11 discursive questions. After the transcript ive of the interview, the recording was erased and the transcription of the interview was stored by the researchers for a period of up to 05 years, where after this period the data will be incinerated.

The participants were invited through the profile called "Waiting for a delivery" of the Social Network of Instagram, where there was the first contact with the women and then were invited by invitation virtually to participate in the research and sharing of their experiences obtained in their natural delivery. The meeting took place on a date and time chosen by the five (participants) and after signing the Informed Consent Form (TCLE).

To participate in the research, the women had to meet the following inclusion criteria: being a follower of the virtual page, enjoying full mental health, being 18 (eighteen) years of age or older, being willing to participate in the research, having undergone one or more natural delivery(s) previously and having signed the Informed Consent. The following exclusion criteria were also considered: not being a follower of the virtual page, not enjoying full mental health, being under the age of 18, not having undergone a natural birth or not having signed the Informed Consent.

Data were collected from October 2020 to April 2021 and transcribed following the reliability of the reports, confidentiality and confidentiality necessary for the research, as well as ensuring the anonymity of the informants. Participants had their names replaced by star names from collection to data presentation. The study participants had the freedom to give up the research at any time, without burden and moral damage.

Memory is explained by the fact that the memories that permeate it are coherent, as well as the goals outside of us need to be, but it is the same natural causality that binds things and thoughts in relation to them. It is through remembrance around memories that it is possible to vary the meaning of the story.[5]

The analysis of the data in this study was theoretically based on the findings of Maurice Halbwachs5; where he discussed how history is personal remembrance situated at the crossroads of the multiple networks of solidarity in

which it is inserted, and as the combination of various elements that can emerge the form of remembrance. Brought in language and still as the consciousness that never ends in itself.

Thus, for the historical description of this study, already understanding that in most reports, as well as the facts narrated, describe experiences experienced by the participants. The analysis took place technically from the following steps: Collection and documentation of raw data. The researchers collected and recorded the data, followed by the analysis of data related to the theme, objective, or study questions; Identification of categories and their components. The data were studied, identified by similarities and differences in statements and behaviors. The classification was followed in order to allow the understanding of the situation or issues under study, preserving the meaning of the context.

For this study, there was a systematic transcription of the recording of the interview. They were then transcribed and examined and separated by affinity and later grouped in the form of themes, which the study will call categories and subcategories. Once categorized, they received appropriate identifications to the oral description of the informant.

The study was approved by the Ethics and Research Committee (CEP) on August 28, 2020 under opinion number 4,244,091.

Results and Discussion

The results for this study are contained in interviews with 5 women, whose profiles are described in Chart 1, as follows.

Table 1- Profile of study participants, 2021.

Identification	Age	Education Level	Marital Status	N. of Children	N. of Natural Births
MAIA	22	Incomplete Higher Education	Married woman	2	2
D'ALVA	34	Incomplete Higher Education	Divorced	1	1
BETA	36	Undergraduate	Single	1	1
RANA	39	Complete High School	Married woman	2	2
TÂNIA	53	Graduated	Divorced	3	2

The discussion for this study had as premise to extract from the participants' reports their life histories and experiences that led them to no longer choose the natural route of delivery for the next pregnancy. Therefore, they will be presented in the form of categories.

Experience with previous deliveries

The women interviewed in this study described their experience in previous deliveries and reported scenes of mistreatment, threats and brutality with them during the prepartum and delivery period:

> [...] I suffered obstetric violence in my first birth (MAIA).
>
> [...] my first experience was not good because the doctor threatened me right? [...] It was a kind of embarrassing way and i still said, "if I'm the one who's going to deliver your birth you'll see!" (D'ALVA).
>
> [...] in my first birth I felt that there was abuse, neglect, lack of humanity in a context with a whole. [...] A doctor came and told me she was going to put the serum to induce childbirth and I asked if i couldn't wait in a more natural way right? She said, "you don't have that option! It's a public unit here and it's got protocol." I was very nervous and scared, feeling sick. I asked her to make a call to my family because I didn't want to stay there and she denied me that right. He said, "This is not a hotel! You have no right to call anyone! [...] I think I took 15 to 20 touches before delivery [...] at the time of taking my son they made a huge cut and sewed [...] then they went to count the paninhos and look at the detail, forgot one inside me! And then they took it with me already sewn, it looked like I was having another baby! It was a festival of horrors that there, a total unpreparedness of the medical team and all (RANA).
>
> [...] every time someone was there and felt entitled to do, it was made a touch on me you know? [...] I cried and asked for God's sake not to do it, I couldn't take it anymore. [...] (TANIA).

Obstetric violence is that that occurs in health institutions, either through a disrespectful or abusive approach during prenatal, childbirth or puerperium. It violates the parturient's rights and can be expressed through violence whether verbal, psychological, physical or negligent[6].

The lack of translucency and centralization of the taking of power in the institution and professional relationship benefits the trivialization of the non-recommended procedures, therefore makes them "normal"[7].

Such behaviors place women, who should be the protagonists of this moment, as inactive. The medical authority on the delivery process makes it impossible to make the right and choice of them in the outcome of the delivery[8].

About complications in previous deliveries

Women report complications that arose with them during the prepartum, delivery and postpartum period:

> My second pregnancy was high risk, I had the bag route and I needed more support (MAIA).
>
> [...] I have mitral valve prolapse, on my pregnant card has written and they did not look at whether or not I could have normal delivery [...] after my delivery the obstetrician said: "You could not have had natural childbirth due to prolapse" (D'ALVA).
>
> [...] my baby was born huge, with 4,210kg. [...] it was super traumatic, he didn't have the slightest condition of being born from a normal birth and they knew it! So much so that they broke my son's collarbone and omitted that fact! And they had the knowledge through my exams and

> yet no one did anything at all. [...] they tore me and sewn me and I said that the anesthesia had not caught right that was to put more and was feeling a lot of pain but did not turn on! (RANA).
>
> [...] in my first daughter I had a hemorrhage [...] in the second had complication due to the rest of placenta (TANIA).

Complications are risk factors that can be divided into previous complications and complications of current pregnancy. These complications imply a more complex follow-up in order to avoid further complications at the time of delivery, remembering the importance of early discovery for better treatment[9].

In the case of complications during prenatal care the woman should be referred to high-risk prenatal care receiving a more specialized and close treatment, analyzing the best form of delivery without putting the life of the mother and baby at risk[10].

Postpartum hemorrhage is considered an obstetric emergency. One of the great factors of maternal morbidity and mortality death. In addition to being able to lead to a hysterectomy when it is not possible to be reversed.[10]

The choice of the route of delivery

The women were asked if they had the opportunity to choose their route of delivery and both reported not having this right:

> [...] I couldn't choose, I had no health insurance and i couldn't have a c-section, I didn't have the support of my son's father and no one else financially, so I had no other option left. (D'ALVA).
>
> What led me to choose natural childbirth was rapid recovery (BETA).
>
> [...] I could choose. I was thinking about speeding up and what would be best for my baby. (RANA).
>
> [...] had no choice because I was going into the public system. (TANIA).

The choice of the route of delivery involves several factors. Most women have a predilection for a pathway, but most report that it did not occur as expected, as they do not feel estimated at the time of choice[11].

Most cesarean deliveries are performed in private hospitals. Many women see cesarean section having more comfort, privacy and easier choice of delivery date, in addition to greater attention in care. Parturients with lower financial condition and resort to the public sector, end up without this right of choice, besides not receiving sufficient guidance during prenatal care, women in the public sector suffer fewer interventions, however they suffer more painful procedures for induction and acceleration of childbirth for example[11].

The physician is the main one in childbirth, making the woman adjunct. Medicalization has transformed medicine as the main focus, in which the parturient is taken from his right of choice [12].

Guidelines on natural childbirth

The women interviewed in this study portray the orientations received about natural delivery during the prenatal and delivery period:

> I had no guidance [...] (MAIA).
>
> I did not have, despite doing the exams and monitoring everything cute I had no instruction in relation to childbirth (D'ALVA).
>
> No, I had the consultations, they looked if the baby grew, the measurements and only [...] (TANIA).
>
> Yes. During prenatal care I attended several lectures, which made me define myself better and even decided that I wanted natural childbirth (BETA).

In prenatal care, pregnant women should be oriented about the risks and benefits of childbirth, the level of risk of each one, the rights of the pregnant woman and parturient. It is important that the woman is assured and that all her doubts are answered[9].

The low orientation provided to pregnant women during prenatal care points to the unpreparedness of professionals who play the role of advisor in the preparation of women at the time of delivery[13].

There is a certain vulnerability of prenatal care follow-up scare to the time of delivery. Most women claim partial orientation or no orientation, these findings may clarify the constant negative results suffered at the time of delivery due to lack of education[14].

Negative experiences with professionals

The women reported having experienced at least one negative experience on the part of the professionals at the time of care:

> [...] the doctor said, "If you scream I'll let you suffer!". [...] I threw up and the doctor said, "Are you crazy? Stop throwing up! He screamed and, in my fear, and despair I tried to swallow the vomit. [...] He talked to the other doctor: "No, how is a 15-year-old girl getting a baby? You should be studying, instead you're having sex!" [...] because my daughter does not, at most gives a few kisses in the mouth (MAIA).
>
> [...] All I remember is that she came in spreading my legs, and at no point did she identify herself, she didn't say a good night at any time, it was like I was a tool. [...] I said, "Doctor, that's no way for you to come and examine me, I'm not a pig!" [...] The doctor hit me on the head and just said, "All right, Mommy... You're not going to let me examine you? I hope I'm not the one giving birth! All right?" and left. (D'ALVA).
>
> So I found the techniques even cool, but the nurses were thick and

> arrogant. The first doctor who attended me was rough even in the touches (RANA).
>
> What got me apart was this doctor wanting to remove the placenta by force without asking what I was feeling right? I'm the one who had to speak up. [...] the other nurse fought with me over the sheet, stating that she was urinating on it, instead of her realizing that I was losing blood (Tania).

According to the Code of Nursing Ethics, nurses in their professional practice must ensure the safety, well-being and protection of the health and dignity of the patient under their care. Thus, nursing care should provide risk-free and undamaged care[9].

The assistance provided expresses negligence, malpractice and recklessness. Neglect is exposed by the omission of care, while malpractice is seen in the disqualification of professionals in the exercise of humanized care during childbirth. Recklessness is expressed from the moment that the professional knows the rights of women and still does not respect them[15].

The practice can go from psychological physical abuse, neglect in pain management ironic phrases and threats disrespect that can cause physical and emotional harm that women take with them [16].

The choice of route of delivery in later pregnancy

The women in the study were asked if they had a new pregnancy later, what would be their choice of the route of delivery follows below:

> I don't want to have children anymore, but if I want to give a cesarean section (MAIA).
>
> [...] my next delivery is going to be c-section. Care in a private hospital is another level (D'ALVA).
>
> Never again [laughs], I found the experience horrible [...] (TANIA).
>
> With the right team I would have normal delivery again yes. With the unknown team I would opt for cesarean section (RANA).

Welcoming parturients is an important process, through humanized care the woman feels safer and consequently has been softened the fear of pain and the process of childbirth [17].

Posttraumatic stress disorders in childbirth are frequent in women with a history of negative experiences in previous delivery. This can promote setbacks and fear in an upcoming birth [18].

A woman who has experienced a traumatic birth can carry sequelae to her psychic health. This event carries a frustration of a dream she carries throughout her pregnancy for the time of her son's arrival. Being able to generate the feeling of disability during and after the process. This can generate the desire to not have more children or the change of the route of delivery in an next pregnancy[19].

Knowledge of the rights of pregnant women

The women interviewed in this study described their understanding of their rights as a pregnant woman and the time of delivery:

> No, none [...] had only the exams and prenatal care. (D'ALVA).
>
> No, I don't know [laughs]. Look to tell you the truth by the time I've never heard of it, first time (BETA).
>
> I don't know these rights (RANA).
>
> I never even knew it existed. I didn't know what's right if I hadn't put my mouth on the trombone (Tania).

The lack of knowledge of women about the rights of pregnant women and parturientwomen increase the fragility of the occurrence of obstetric violence [20].

Among the multiparous women, the self-image of normal childbirth is based on the previous experience experienced. This implies fear and insecurity depending on previous experience. It is noteworthy that women choose the route of delivery based on the experiences of friends and family members[21].

Unnecessary interventions and obstetric violence suffered by women in childbirth transform what would be a physiological process into a traumatic and dehumanized procedure. This increases the feeling of pain and fear, this contributes to a choice for cesarean delivery later[22].

Suggestions for care to professionals in the care provided to pregnant women

The women in this study proposed a form of assistance for health professionals in view of the support they received in their care at the time of pregnancy and delivery:

> [...] I believe we have to choose an area that you identify with, that you like. We should treat others as we would like to be treated, it is a time when the mother is delicate, feeling pain and will meet her child for the first time after carrying so much time. This moment, even though it's painful, it has to be gratifying, we have to prepare mom for one of the best moments in her life. We must have a more humanized, dedicated care, not judge, because it affects people's lives (MAIA).
>
> [...] a more humanfollow, without a doubt, since the screening when they take our card, have a more humanized delivery, give more security. Receiving information like, "you're going to go through this, don't worry that it's normal." Everything I didn't have. Pay attention to the technician, nurse or doctor to avoid the feeling of being alone. (D'ALVA).
> The suggestion I would give is the team ask about what we want, whether it is normal or not, whether we want to be cut or not at the time of delivery. Because things are happening and they make the decisions that must be made. And we are not informed of anything, only after it happens (BETA).
>
> So I guess for things to work better, it would be the question of humanity right? From having empathy that each one faces pain in a

> way, I think the respect of the person if they are saying that it is hurting a lot, it is not you who will judge her! We get sensitive, needy, we're there with no one on our side, there's only the medical staff and the nurses. I think it should have more humanity in this sense, have more human warmth right? You don't treat people in a mechanical way every person is in a way! [...] I think these things that treatment makes it much easier! (RANA).

The Prenatal and Birth Humanization Program was legalized by the Ministry of Health through Ordinance/GM No. 569 of 6/1/2000. The main focus is access and quality assistance respecting women's rights as citizens. Its main criterion is humanization in obstetric care[23].

In the birth process the opinions and feelings of the woman are important, the puerpery complain sofone women complain about only having to follow the guidelines, not having the right to give their opinion [24].

The reports and experiences of negative experiences at the time of delivery brings a reflection and visibility on the theme obstetric violence. The subject should be more addressed in professional training programs, as a way to incite professionals that the act has repercussions for that woman.[16]

Feelings about what happened

Given all the experience they had at the time of delivery, the women in this study leave their feelings in relation to what happened at the time of their natural delivery:

> [...] In addition to feeling alone and the threat of the doctor who felt like saying that she would do something with the patient in front of her and my mother's assistant [...] The impression is that you are in a slaughter ready for the time of cutting (D'ALVA).

> So I think that's really it! It was an abuse and total disrespect, talking about it causes me pain to this day and makes me feel bad and I took 5 years to get another child (RANA).

> "I suffered obstetric violence in my first birth" (MAIA).

> "I was very traumatized for a long time by what happened [...] because of this I lost contact with my son for a month" (Tania).

The abusive use of unnecessary interventions can mirror negative feelings. It can generate a feeling that natural childbirth does not have so many benefits and ends up using a cesarean section later. In addition to giving rise to negative experiences and may become a feeling of disturbance to what happened and associated with all deliveries.[25]

Obstetric violence prevents the bond of the professional/patient and the promotion of health in a humanized way. This fact has contributed to women increasingly associating and identifying natural childbirth with the feeling of pain, suffering and accepting the whole process without commenting.[11]

The correct one would be a humanized care with all the guidelines on childbirth and women's rights. This would prevent anxiety, insecurity, fear and greater autonomy of women in the face of childbirth.[26]

Final Considerations

The study met the proposed objectives, revealing the negative experiences faced by the participants at the time of delivery in the face of the care received and how this affected their view of the benefits of natural childbirth in the face of this experience.

This study, despite meeting the objectives, showed the feeling of fragility of women at the time of delivery, being inferiorized and subjugated by their gender, to the point of having to accept the whole situation as patients with their rights violated. Also to think about the preparation of the nursing team and other professionals working in the area. I prepare this that does not simply imply in the discourse of humanization, but in training, in-service training and in constant evaluation of the conducts taken in the day-to-day.

Thus, this study proposes new research, opening new precedents to investigate also the experience and opinion of these professionals, which makes them have such divergent behaviors in relation to the care provided in practice, since the main function of the team is to welcome, support, guide and provide a humanized care to women. In addition, nursing professionals spend most of their time at the side of women. It exposes the need for the importance of the practice of integral humanization to women in the process of childbirth and efficient participation in care.

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Experience of women after mastectomy

Vivência de mulheres após a mastectomia

Experiencia de la mujer depués de la mastectomía

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RESUMO

Objetivo: descrever a vivência de mulheres após a mastectomia na Rede Feminina de Combate ao Câncer, tendo como problema de pesquisa a seguinte questão: De que maneira a Mastectomia influencia na vivência da mulher? **Método:** Foi utilizada a abordagem qualitativa e método de história oral seguindo os pressupostos de Halbwachs. A coleta dos dados deu-se por meio de entrevista com mulheres cadastradas na Rede Feminina, que receberam nomes fictícios de países e que foram submetidas à mastectomia. **Resultados:** Foram entrevistadas 04 participantes com idade mínima de 47 e máxima de 76 anos e com diferentes graus de escolaridade, que responderam os questionamentos a respeito de sua vivência pós a mastectomia. **Conclusão:** A discussão apresenta-se por meio de 05 categorias que descrevem a vivência destas mulheres em relação à autoimagem, espiritualidade, sexualidade e até relacionada às relações afetivas que foram grandemente influenciadas pelo aparecimento do câncer e posteriormente à mastectomia.

Descritores: Mastectomia; Saúde da Mulher; Enfermagem.

ABSTRACT

Objective: to describe the experience of women after mastectomy in the Women's Network for the Fight against Cancer, having as a research problem the following question: How does mastectomy influence women's experience? **Method:** A qualitative approach and oral history method were used following the assumptions of Halbwachs. Data collection took place through interviews with women registered in the Women's Network, who received fictitious names of countries and who underwent mastectomy. **Results:** 04 participants were interviewed with a minimum age of 47 and a maximum of 76 years and with different levels of education, who answered questions about their experience after mastectomy. **Conclusion:** The discussion is presented through 05 categories that describe the experience of these women in relation to self-image, spirituality, sexuality and even related to affective relationships that were greatly influenced by the onset of cancer and after the mastectomy.

Descriptors: Mastectomy; Women's Health; Nursing.

RESUMEN

Objetivo: describir la experiencia de las mujeres después de la mastectomía en la Red de Mujeres de Lucha contra el Cáncer, teniendo como problema de investigación la siguiente pregunta: ¿Cómo influye la mastectomía en la experiencia de las mujeres? **Método:** Se utilizó un enfoque cualitativo y método de historia oral siguiendo los supuestos de Halbwachs. La recolección de datos ocurrió a través de entrevistas con mujeres registradas en la Red de Mujeres, que recibieron nombres ficticios de países y que se sometieron a mastectomía. **Resultados:** Se entrevistó a 04 participantes con una edad mínima de 47 y máxima de 76 años y con diferentes niveles de escolaridad, quienes respondieron preguntas sobre su experiencia después de la mastectomía. **Conclusión:** La discusión se presenta a través de 05 categorías que describen la experiencia de estas mujeres en relación a la autoimagen, espiritualidad, sexualidad e incluso en relación a las relaciones afectivas que fueron muy influenciadas por la aparición del cáncer y después de la mastectomía.

Descriptores: Mastectomía; La Salud De La Mujer; Enfermería.

ORIGINAL

Introduction

Breast cancer is a disease caused by the disorderly multiplication of breast cells. This process generates abnormal cells that multiply and create a tumor. There are some types of breast cancer, so it can arise in different ways. While some types have rapid development, others grow more slowly. These distinct behaviors are due to the nature of each tumor. Breast cancer is the most common type of disease among women worldwide and in Brazil, after non-melanoma skin, corresponding to about 25% of new cases each year. In Brazil this number is 29%.[1]

There are several factors for the development of breast cancer in women. Age is one of the most important risk factors for the disease. About four out of five cases occur after the age of 50. Other factors that increase the risk of the disease are: environmental and behavioral factors (obesity and overweight after menopause, alcohol consumption and frequent exposure to ionizing radiation), factors of reproductive and hormonal history (first menstruation before 12 years, stop menstruating (menopause) after 55 years and have done postmenopausal hormone replacement, mainly for more than five years) and genetic and hereditary factors (cases of breast cancer in the family, especially before the age of 50, family history of ovarian cancer).[1]

Some healthy habits such as physical activity, eating healthily, avoiding alcohol and using synthetic hormones can prevent about 30% of breast cancer cases.[1]

Breast cancer can be seen in early stages, in some cases by signs and symptoms such as nodule, reddish-retracted or orange peel-like breast skin, changes in the areola, small nodules in the armpits or neck, and spontaneous outflow of abnormal fluid from the nipples. These signs and symptoms should always be investigated by a health professional to assess the risk of cancer. Imaging tests such as mammography, ultrasound or magnetic resonance imaging are used for the investigation, in addition to clinical examination of the breasts. Confirmation only and made with the result of a biopsy, a technique that removes a fragment of the nodule or lesion, by means of a puncture or small surgery.[1]

There are several forms of treatment for breast cancer, which depends on the type and stage of the disease. Local treatments aim to treat the tumor locally without reaching the rest of the body, including surgery and radiotherapy; systemic treatments are done through the use of oral or bloodstream medications. According to the type of breast cancer, different types of systemic treatments can be used as chemotherapy, hormone therapy, target therapy and immunotherapy. Most women with breast cancer will have some kind of surgery to remove the tumor. Depending on the type of tumor and staging of the disease, you will also need other forms of treatment.[2]

Mastectomy is one of the ways to treat breast cancer consisting of the removal of the entire breast with surgery. This is usually done when a woman cannot be treated with breast-conservative surgery, which saves most of the breast. Mastectomy may also be an option rather than conservative surgery, for reasons people.[2]

There are some types of mastectomy, depends on how the surgery is done and while tissue and removed.[2] - Simple mastectomy. It is the most common and used in the treatment of breast cancer. In this procedure, removes the entire breast with surgery, including the nipple, but does not remove the axillary lymph nodes and muscle tissue under the breast.[2] - Double mastectomy. She is performed in both breasts, this procedure is sometimes preventive, for women at high risk of developing cancer in the other breast, such as those who have mutation in the BRCA gene.[2] - Skin-sparing mastectomy. For the immediate mamaria reconstruction of some women. In this procedure, most of the breast skin and preserved. In these cases the same amount of tissue is removed as in simple mastectomy surgery.[2] - Nipple-Sparing Mastectomy. This is a variation of skin-sparing mastectomy. This is an option for women who have small early stage tumor on the outside of the breast, with no signs of skin disease or near the nipple. The procedure removes breast tissue, but breast skin and nipple are preserved, followed by breast reconstruction.[2] - Modified Radical Mastectomy. Modified radical mastectomy is simple mastectomy with the removal of axillary lymph nodes, called axillary lymph node dissection.2 - Radical mastectomy. In this process, the doctor removes the entire breast, axillary lymph nodes and pectoral muscles. This surgery can be done for larger tumors that are growing in the pectoral muscles.[2] Given this assumption, this study is based on the following research question: How does mastectomy influence women's experiences?

The aim of this study was to describe the experience of mastectomized women at the Women's Cancer Network Institute in Brasília, Federal District. The study becomes relevant because it may present data on women who underwent mastectomy, being useful also for health professionals in academic training or not.

Methodology

The methodology for this study was a qualitative approach and oral history method following the assumptions of Halbwachs.[3] The historical methodology is always based on some narrative. Data collection was through an interview recorded with an appropriate equipment through a smartphone and was later transcribed by the researchers, following the ethical principles and anonymity, reliability and confidentiality of the data.

The place of the interview chosen by the participant was at her residence. Data were collected from September 20 to October 20,

2020. Five (5) women who agreed to participate in the study with the following inclusion criteria were chosen: To be considered as such, the women who agreed to participate in the research met the following inclusion criteria: signed authorization, aged 18 years or older, is in good mental health, was willing to participate in the research and sign the Informed Consent and is part of the Women's Network to Combat Cancer in Brasilia. Women who presented the following exclusion criteria were excluded from the study: age below 18 years, not having good mental health, not being willing to participate in the research or lack of signature of the Informed Consent, and if she is not a patient of the Women's Network to Combat Cancer in Brasilia. Exclusion factors were not: race, different creeds and cultures, sexual options and different socioeconomic factors.

The study was approved by the Ethics and Research Committee (CEP) on August 28, 2020 under opinion number 4,244,091.

Results and Discussion

The participants of this study received fictitious names as a way to maintain their anonymity according to the following table:

Table 1- Profile of study participants, 2021.

Identification	Age	Education Level	Marital Status	Time of Mastectomy
Cuba	59	Primary education	Single	18 years
Chile	47	High School	Married	2 years
Paraguay	51	Higher education	Single	5 years
Mexico	76	Higher education	Married	23 years

The discussion of this study gave rise to 05 categories that best fit the participants' reports, as presented below.

The post-mastectomy experience

The participants of this study reported their experiences after mastectomy, where there were significant and impactful changes in life, such as: the way of seeing life, discomfort and physical pain, self-acceptance, self-image and the fear of a recurrence of cancer, according to the following reports.

> My life has changed a lot, the way I see life, even family, you know? With friends... I've learned to value family a lot, and many friendships that have never abandoned me. (CUBA).

> [...] has the discomfort ne? because, whether or not this stirs a little with the posture, I end up putting the shoulder inward [...] God gave me conformism, acceptance. I know that and a phase, I'm waiting to do my breast reconstruction, so so, it's more this question of self-esteem even right? [...] I'm looking forward to doing the reconstruction, of course ne? For an improvement in self-esteem, this issue of you being able to

> wear a bikini, wear a bathing suit, I could not do that after the mastectomy, but what about this (CHILE).
>
> [...] it was very difficult, it took me a long time to accept myself and look in the mirror [...] it seemed like I wasn't the one who was seeing it there, it felt like I was watching a movie [...] it was very difficult for you to face, it's very ugly [...] you feel like you're missing something, your body shows you that this [...] you start having shoulder pain, pain in the arms, back pain and itching in the nipple, and I did not have it (PARAGUAY).
>
> [...] Every time I went to the doctor, I was very tense, very worried, thinking I had come back ne? [...] the difficulty with the left arm from which it was, the side that was operated. I adapted, because with this arm I can't push too hard, get hot. I can't do a lot of things because all the lymph nodes were taken. (MEXICO).

In the patient undergoing surgical treatment of breast cancer, the stigma of the disease, mutilation, aesthetics, the limitation of activities of daily living after surgery, the routine of tests, treatments (chemotherapy, radiotherapy) and the short and medium-term effects are not the only disorders shown. Breast failure or modification brings physical, psychosocial, sexual and emotional impacts that will directly affect your quality of life. [4]

The feeling of bodily integrity is indispensable for the human being. The well-being related to this condition is expressed in the way each one sees himself and, as a result, in the activities they develop. Within this situation, mastectomy is established as a situation of withdrawal of part of the competence to perform tasks and self-esteem; imposing a decline in quality of life, which also concerns the level of physical activity of women submitted to it. [5]

Mastectomy remains the most used strategy for the treatment of breast cancer; In addition, breast withdrawal and other fundamental treatments for the complete elimination of cancer cells that contribute to the emergence of physical and psychological complications, factors that can influence in a harmful way to these women. [6]

Post-mastectomy spirituality

The participants of this study reported the importance of faith in God after undergoing surgery. a more direct contact with God, hope and faith at this time, as follows:

> [...] I think treatment is both, religion and medicine, because I think without God doctors wouldn't have such a great intelligence to take care of us. [...] I try to do my part, because what God has done in my life is a miracle even (CUBA).
>
> [...] spirituality, faith, strength, hope in God. That's of the utmost importance ne? Your psychological has to be fine for you to face the treatment and be well (CHILE).
>
> [...] after this happened to me I started to have a direct connection with God, [...] it's amazing I felt that God listened to me, so I already put it in my head that God was listening to me [...] God does not just hold my hand, he carries me in his lap and holds me in both hands as if a baby had learned to walk (PARAGUAY).

> [...] without you believing in God, having a faith, established in what you believe, in the God you believe, you do not walk. [...] I say thus, that this disease has three strands that lead to healing: first is God, second is his head and third is the doctor. If you don't have these three pillars you don't get there (MEXICO).

Religious beliefs and practices contribute to the rescue of forces lost at each stage of treatment, offering emotional support, and reliving life expectancy in the future.[7]

Spirituality appears as an expression of identity and perception of personal life, erected from history itself, experiences and longings. In this sense, faith and the search for spirituality have the power to alleviate the suffering of the patient, involving the suffering of family members, allowing a change of thought about the fact of illness.[8]

The experience of illness increases religious convictions, where faith plays a fundamental role in going through the disease process in an affirmative way.[9]

Self-image post mastectomy

The participants of this study reported that body image is a cause for concern for them, leading to changes in their daily life, such as not looking in the mirror, clothing-related deprivation and weight gain.

> [...] so I'm quiet, I've never had prejudice at all, I'm quiet, I walk on the street good, I feel beautiful. Even at the time of treatment, doing chemotherapy and bald, I never gave up my lipstick or my earring, ever (CUBA).
>
> [...] sometimes I have a certain deprivation, I can not wear everything I wanted, sometimes I will wear a blouse, a dress, a more low-cut thing, i can not use [...] there is a change there, sometimes I look in the mirror and I do not like what I see (CHILE).
>
> [...] if looking in the mirror was very difficult, it took me a long time to accept myself and look at myself in the mirror. [...] I started to notice that I no longer looked in the mirror, when I was going to pass cream, when I was going to moisturize the body, when I was going to do simple things. [...] You feel like something's missing, your body shows you something's missing. [...] suddenly you see yourself without a breast, having to touch your life, having to want to survive, which is the most important (PARAGUAY).
>
> "I was upset because I put on a lot of fat [...] I've always been very careful to wear a proper bra, wear suitable clothes that for example [...] What really upset me was that the arm swelled too much ne? I had to do a lot of lymphatic drainage (MEXICO).

Breasts, in addition to aesthetic appearance, have serious meaning in women's sex lives. Mastectomy, considered by many women as mutilation, can constitute several emotional signs.[10]

The breast is one of the symbols of female identity and its reconstruction is of great importance for the patient to regain self-esteem, thus helping to recover the disease and restore social activities, bringing these women to good levels of quality of life, besides the effects being aesthetically satisfactory.[5]

Such representations of the woman's body, of perfection and beauty, are reactions of a social construction in the way of idealizing the female body, requiring its good shape. These elements are socially shared and influence the self-esteem of women who undergo changes in the body.[11]

Post-mastectomy sexuality

The need to create this category was somewhat thought-provoking, in the sense that when asking about sexuality for these women, they answered something related to the presence of the partner or to the sexual encounter itself, as if sexuality was summing up to just that. It is also important to elucidate that sexuality is related to self-esteem, self-confidence, self-image, desire and others, which would make it partly difficult to maintain an affective and intimate relationship, as follows:

> [...] husband at the time had not already, as for this there did not change much no, but so, it was an impact for treatment, changes psychologically, much changed for me (CUBA).
> [...] you can't be that normal thing, just like it was before, [...] I can't be as exposed as I was, [...] but you're kind of private, ashamed, I think it's normal (CHILE).
> [...] I was already divorced, had a relationship, but it was over [...] I never had any relationship, I say today that I don't want to have anymore. [...] an independent life option, I don't want to have anymore. What I think is cool about all this is that I did the reconstruction for myself (PARAGUAY).
> "I got very cold, for me the sexual relationship was the last thing I thought about in my life, that for my head was very distant, what I wanted was to lie down and settle down (MEXICO).

Women represent more difficultbecause they are directly affected by the transformation in their bodies, which causes a change in body image, where breast loss is understood in feelings of acanho, inferiority, shame, inhibition and low self-esteem, the woman begins to feel unable to act as a woman before society and partners.[11]

In addition to compromising their functional skills, mastectomy and treatment have a significant impact both on women's lives and on their family group, social environment and group of friends. The constraints added to the stigmatizing disease often lead women to distance themselves from their social life.[12]

Mutilation modifies self-image and self-concept, leading women to feel less valued, ashamed and repulsive, moving away from social and sexual contacts.[13]

Interpersonal relationships after mastectomy

In the present study, the participants reported the support of the family in a positive way, highlighting the importance of this support to face the day-to-day after mastectomy, as follows:

> [...] It was of great importance, my mother, my nephews, so... Family from afar supported me, wow! My family [...] my family was too important in my treatment, very much after, after also, to this day I am the darling of the family (CUBA).
> [...] family and very funny, because so, it's not just me, but sometimes at that moment your family that welcomes you, that you tell, is more your friends. A friend who you consider sister for a long time, that you have more this welcome, this affection of people, but outside of that family. My mother does not live here in Brasilia, so I could not have this support, this close welcome (CHILE).
> "I had a lot of support from my father, from my mother, and they did everything. [...] always have such a feeling of pity, I felt that they had a lot of pity for me (PARAGUAY).
> [...] I knew that all of them (family) were aware, they knew it was a serious thing and that I was in need of help, and that their pity was not going to help me (MEXICO).

Friends are important in supporting and supporting women with breast cancer, but the main and indispensable role is that of the family. The family has to organize themselves in such a situation, since it is the family members who will give the first support to the mastectomized woman, who will respond to the new needs that will appear in the course of the situation, such as the health care of this woman and the social environment.[12]

The repercussion in the family did not refer to the reorganization necessary to respond to the needs of routines and care for women's health, also reaching the other relationships.[14]

The presence of the family in the treatment of breast cancer and in the recovery of mastectomized patients plays a very important role, since it is one of the main supports that the patient finds to deal with the stress added to the treatment, such as breast removal, as well as self-image problems and sexuality.[8]

Final considerations

Given the above, the results met the objectives of the study, which showed body self-image, a problem widely cited by the interviewees, who feel uncomfortable, mutilated and impaired by breast failure. On the other hand, they report that their spirituality has changed significantly, in view of the increase of faith and trust in God, according to the belief of each one.

Of the implications that this study has for Nursing, it is important to highlight that, humanized care in order to provide physical and psychological well-being to mastectomized women is the main legacy of this study. In addition, the data presented here are of fundamental importance for nursing professionals, since it helps them in the creation of reception strategies in order to develop a comprehensive and dignified care for women.

Finally, this study leaves open as a suggestion for new research the need to evaluate the feelings of mastectomized women after breast reconstruction. This is due to the fact that the results obtained in this research in relation to experience, spirituality, interpersonal relationship, self-image and sexuality may be different for those women who did breast reconstruction.

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Consequences of cesarean delivery without clinical indication

Consequências do parto cesárea sem indicação clínica

Consecuencias de la cesárea sin indicación clínica

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RESUMO

Objetivo: analisar o conhecimento sobre as consequências do parto cesárea sem indicação clínica por mulheres da rede privada. **Método:** A metodologia utilizada foi de abordagem qualitativa e método descritivo seguindo os pressupostos de Minayo. **Resultados:** A coleta de dados ocorreu em uma página virtual da rede social Facebook designada Espaço Gestante. Teve como critérios de inclusão para participar mulheres que tiveram parto cesárea sem indicação clínica e que tiverem idade igual ou superior a 18 anos, que aceitaram o convite e concordaram com o Termo de Consentimento Livre e Esclarecido. A entrevista ocorreu por meio da ferramenta de formulário Google Forms, onde as participantes responderam a um questionário de 7 perguntas norteadoras. A análise de dados ocorreu concomitantemente a coleta de dados, seguidamente foram transcritos e agrupados conforme a semelhança. Nos resultados foram entrevistadas 5 mulheres com idade entre 23 e 42 anos, que tiveram ao menos uma cesárea. **Conclusão:** Na discussão foram apresentadas 6 categorias, dentre elas a de maior relevância a orientação sobre riscos e consequência da cesárea sem indicação clinica onde se revela divergência quanto as orientações recebidas de riscos do procedimento. É preciso ser analisado o nível de importância dado ao acesso as informações pelas mulheres sobre indicação, riscos maternos e fetais e o seu direito a participar efetivamente no processo de decisão da escolha da via de parto.
Descritores: Saúde da mulher; Enfermagem obstétrica; Cesárea.

ABSTRACT

Objective: to analyze the knowledge about the consequences of cesarean delivery without clinical indication by women in the private network. **Method:** The methodology used was a qualitative approach and descriptive method following the assumptions of Minayo. **Results:** Data collection took place on a virtual page of the social network Facebook called Espaço Gestante. The inclusion criteria for participating were women who had cesarean delivery without clinical indication and who were 18 years of age or older, who accepted the invitation and agreed to the Free and Informed Consent Form. The interview took place through the Google Forms form tool, where the participants answered a questionnaire with 7 guiding questions. Data analysis occurred concomitantly with data collection, then they were transcribed and grouped according to similarity. In the results, 5 women aged between 23 and 42 were interviewed, who had at least one cesarean section. **Conclusion:** In the discussion, 6 categories were presented, among them the most relevant guidance on risks and consequences of cesarean section without clinical indication, where divergence regarding the guidelines received on the risks of the procedure is revealed. It is necessary to analyze the level of importance given to access to information by women about indication, maternal and fetal risks and their right to effectively participate in the decision-making process of choosing the route of delivery.
Descriptors: Women's health; Obstetric nursing; Cesarean section.

RESUMEN

Objetivo: analizar el conocimiento sobre las consecuencias del parto por cesárea sin indicación clínica por parte de las mujeres en la red privada. **Método:** La metodología utilizada fue de enfoque cualitativo y método descriptivo siguiendo los supuestos de Minayo. **Resultados:** La recolección de datos ocurrió en una página virtual de la red social Facebook llamada Espaço Gestante. Los criterios de inclusión para participar fueron mujeres que tuvieron parto por cesárea sin indicación clínica y que tenían 18 años o más, que aceptaron la invitación y accedieron al Término de Consentimiento Libre e Informado. La entrevista se realizó a través de la herramienta de formularios Google Forms, donde los participantes respondieron un cuestionario con 7 preguntas orientadoras. El análisis de los datos ocurrió concomitantemente con la recolección de los datos, luego fueron transcritos y agrupados de acuerdo con la similitud. En los resultados se entrevistaron 5 mujeres con edades entre 23 y 42 años, que tuvieron al menos una cesárea. **Conclusión:** En la discusión se presentaron 6 categorías, entre ellas las orientaciones más relevantes sobre riesgos y consecuencias de la cesárea sin indicación clínica, donde se revela divergencia en cuanto a las orientaciones recibidas sobre los riesgos del procedimiento. Es necesario analizar el nivel de importancia otorgado al acceso a la información por parte de las mujeres sobre la indicación, los riesgos maternos y fetales y su derecho a participar efectivamente en el proceso de toma de decisiones de elección de la vía del parto.
Descriptores: Salud de la mujer; Enfermería obstétrica; Cesárea.

ORIGINAL

Introduction

Cesarean section is one of the oldest in medicine, its origin remains unknown, since history presents some controversial versions about the procedure. At its origin, the cesarean section was performed to save the life of the conceptus, when the parturient was dying. Currently, cesarean section has evolved into a safe procedure, which can be planned and is often performed at the woman's choice and medical convenience in cases without a clinical indication, resulting in exponential increase in the operation.[1]

In cesarean section, an incision is made in the abdomen and wall of the uterus for removal of the conceptus. The woman is submitted to anesthesia, usually spinal anesthesia, but in cases where during labor cesarean section was indicated, epidural anesthesia is also adequate[2].

Cesarean surgery is an important method used in cases with complications, to ensure greater safety for women and fetuses. However, maternal morbidity and mortality rates are higher in cesarean sections, so their choice should be substantiated, where the benefits should outweigh the risks[3].

Cesarean rates have been growing worldwide, this increase is associated with cultural changes, improvements in the technique, the provision of information about it and the influence of obstetricians who spread their practice by choice of the parturient as a form of autonomy over the choice of the route of delivery, in addition to the economic factors involved[1].

By 2020, the cesarean rates presented by health operators in recent years are above 80%. In 2017 and 2018, 83% of deliveries were cesarean sections and in 2019 were 83.2%[4].

The cesarean rate in countries with good medical care does not exceed 28% in all customer profiles. In the public system of Brazil the value is between 40 and 50% of births, but in private hospitals the value is much higher reaching 90% in some cases. The Ministry of Health has been employing measures to reduce these rates, since there is no evidence that these rates are associated with improved care[3].

Determine an optimal rate of reckless cesarean section, since it is not possible to perform a broad and safe global analysis to apply in the individuality of each country. There are no studies that provide clear evidence on cesarean rates above 10% on mortality and morbidity[1].

The high rates of cesarean sections performed in Brazil show that at the time of choice of the mode of delivery women tend to opt for cesarean section even in situations where normal delivery is possible, so it is necessary to understand how women are instructed about the consequences of cesarean delivery. This study presents the following problem: What knowledge does the woman have about the consequences of cesarean section without clinical indication?

This study becomes important because it can equip obstetric nurses in order to improve the orientation of pregnant patients in the private network to obtain data regarding their knowledge and how women understand this process.

It may demonstrate that the guidance and assistance of the health team can influence the choice of women by cesarean section, and thus stimulate the improvement in the provision of information, as well as influence new research in the area.

This study aims to analyze the knowledge about the consequences of cesarean section without clinical indication by women from the private network users of the social network Facebook.

Methodology

This study used with the qualitative approach and descriptive method, following the author Minayo (2014)[5]. This method describes an event by analyzing in detail.

Data collection took place from June to August 2021 on a virtual page of the Social Network Facebook called Pregnant Space, through an electronic form of Google Forms, where participants answered a questionnaire of 7 guide questions.

The participants were invited to participate through a written statement with a brief clarification regarding the objective of the research. After the participants agreed to participate in the research, they were contacted to schedule the interview. The inclusion criteria were to participate in women who were members of the virtual group, who were 18 years of age or older and enjoy full mental health, had cesarean section without clinical indication previously and who accepted the invitation and agreed to the Free and Informed Consent Form.

It also had as exclusion criteria women who were not members of the virtual group, did not enjoy full mental health, under the age of 18 years, did not have passed cesarean section without clinical indication or did not agree with the Informed Consent.

Considering resolution 510/16 that provides for the guarantee of rights and duties to research participants, as well as those covered by bioethical factors such as autonomy, justice, among others. The data and information collected were used in a reliable way maintaining the confidentiality and confidentiality of the participants as determined by the resolution they had their names replaced by flower names.

Given the resolution, this study did not benefit any of the participants, as well as had their right guaranteed to, in their freedom to give up the research without causing the same losses.

The data analysis of this study occurred following the steps of ordering the data, this step includes the rereading of the material, the organization of the reports in a given order with a beginning of classification giving the researcher an overview of the material, ordering in sets and subsets in order to obtain a reading that seeks similarities and differences through comparations and contrasts between each other. In the classification occurred the horizontal and exhaustive reading of the texts, the researcher at that moment had all his attention focused on the material. During the reading, the researcher made notes about his impressions, starting the search for the coherence of the information obtained, performing a careful analysis.

Subsequently, a cross-verse reading occurred, of each subset obtained and of the whole set in order to perceive the connections between them and establish relationships of similarity and logic. In the final analysis of this study, the researcher analyzing the material studied sought to present the answers obtained in order to clarify the logic presented to the group's behavior on the subject studied and finally the report with the synthesis of the objective of this study and the interpretation of the researcher of the results obtained.

The study was approved by the Ethics and Research Committee (CEP) on June 1, 2021 under opinion number 4,748,047.

Results and Discussion

The participants of this study were 05 women who had their identifications preserved and fictitious names were assigned the same according to the following table.

Table 1 - Profile of participants, 2021.

Fictitious Name	Age	Marital Status	Education	N. of Deliveries
Sunflower	42	Married	Incomplete Higher Education	2
Lily	23	Single	Incomplete Higher Education	1
Rose	32	Married	Incomplete Higher Education	1
Daisy	35	Married	Complete High School	2
Tulip	26	Married	Complete Higher Education	1

Choice of the route of delivery

The informants in this study reported how they were choosing the route of delivery, as follows:

> From the moment I had an abortion, it was very painful did not want to wait whenever 38 weeks the doctor removed the baby (GIRASSOL)
>
> Since the beginning of pregnancy. I was able to choose to have a covenant (LILY)
>
> At the beginning of pregnancy (ROSE)
>
> Since the beginning of pregnancy, I have always said that I would only have caesarean section (DAYSY)
>
> End of pregnancy. I had everything to be normal. Then she (the doctor) asked if I wanted to score because then she would do but normal would not give with her, then in the end was a choice of mine (TULIP)

Women assisted by the supplementary health network enjoy the right to choose the route of delivery and opt for cesarean delivery mostly, being evidenced by the high rates of cesarean sections performed in private hospitals[6].

The care provided in the private network provides a greater autonomy to the woman over the decision on the choice of the route of delivery. However, there is a priority for cesarean delivery in the supplementary health network, during the time women who previously desired a normal delivery decide to give up a cesarean section[7].

It is the right of women to participate in the choice of the route of delivery, she has the right to choose cesarean delivery and her desire must be respected by the professional. However, it is verified that there is an excess in the performance of the procedure[8].

Guidance on indications and risks of cesarean section at the time of choice of delivery route

About the orientation received when the woman chose the route of delivery, the participants' responses were very heterogeneous, where some were informed and others were not.

> He (the doctor) did not guide me, but my decision would be cesarean section (SUNFLOWER)
>
> Yes. My mother's a nurse and she explained everything to me. Together with the doctor I opted for cesarean section (LILY)
>
> I chose cesarean section, was not aware of possible risks (ROSE)
>
> I was not informed about the risks (DAYSY)
>
> Yes. At the last pre-delivery consultation (TULIP)

The woman and her legal guardian must be aware of the risks and adverse events that can potentially be caused by cesarean delivery, as well as the administration of medications for the surgical procedure[9].

Information on the risks and benefits of a cesarean delivery compared to normal delivery is often overlooked, and these when passed on are passed on by the medical professional predominantly. Past guidelines do not cover all the doubts of women[10].

Health professionals have the role of educator and advisor in the selection process. The dialogue should be clear and cover all the points necessary for women's understanding of the risks and benefits of the procedures to which they will be subjected[11].

Doubts clarified during the orientation about the choice of the route of delivery

The participants of this study describe their understanding of the clarification of doubts, where the results were divergent as follows.

> Yes, I had no doubt that my choice would be the c-section I came to see a normal delivery in the hospital xxx saw how much was suffered for woman I did not have the courage to face (SUNFLOWER)

> Yes (LILY)
>
> No, because from the beginning I told the doctor I wanted a C-section and he didn't question me (ROSE)
>
> No, it was hit at the beginning of pregnancy and I didn't ask any more even with doubts (DAYSY)
>
> No. Had the birth and there were still doubts (TULIP)

By law, the woman must understand the information and guidance received about her condition, as well as about the procedures to which she may be submitted and duly informed to refuse in a free and enlightened manner. In case of remaining doubts, they should be instructed[12].

The orientations carried out during prenatal care are centered on the alterations of pregnancy. Information about childbirth, postpartum and its specifications are not the priorities in care[13].

The health care provider must inform her and guarantee her rights. The same when choosing to perform a cesarean delivery should sign the Free and Informed Consent Form, after detailed dialogue on risks of the procedure in cases without indication in order to ensure a conscious and oriented choice[14].

Support and support by the team in choosing the route of delivery

Regarding the involvement with the care team, the women declare a good interaction:

> Very good, support from the obstetric doctor, nurses before and after cesarean section (SUNFLOWER)
>
> Wonderful. It was at the hospital that my mother worked as a nurse, she attended the birth and the whole team worked with her (LILY)
>
> Very good, respected my choice (DAYSY)
>
> Comprehensively (TULIP)

The women assisted in the private network show greater satisfaction with the assistance offered. The interaction with the care team is respectful and satisfactory in general resulting in a pleasant experience for women[13].

The relationship of trust developed during prenatal care between doctor and patient contributes to a favorable evaluation of the care and care received. The quality of care is evaluated contaminant to the respect and reception received by the woman[10].

The autonomy of women over decision-making about the type of delivery is ethically accepted at the medical level, provided that the woman is aware and oriented about the procedure to be performed. The medical professional is still guaranteed the autonomy of referring the patient to another professional in case of disagreement between the woman's desire and the medical decision[15].

Factors that influenced the choice of a cesarean section

Women describe which factors led them to opt for a cesarean delivery:

> Due to an abortion and an unsuccessful curettage, I suffered a lot due to this never wanted to wait for a normal delivery (SUNFLOWER)
>
> Fear of having complication and my daughter being born without oxygen bringing sequelae (LILY)
>
> Pain, thought I would feel a lot of pain in normal childbirth (ROSE)
>
> Fear of feeling pain, and having a bad experience (DAYSY)
>
> Normal delivery in the public hospital without knowing what the doctor would be scared, because of the reality in which the hospital was. With several cases of neglect (TULIP)

In Brazil, deliveries performed by the supplementary network enable women to participate more in the choice of delivery route. However, it suffers medical, social and family influences to choose the abdominal route, on the grounds that cesarean delivery is safer and it is possible to prepare for the event. Another important point is the perception that cesarean delivery causes less pain to women, which to many women is a strong fear in relation to childbirth[16].

The autonomy of the woman is guaranteed when she is able to make her decision by holding all the information about consequences and benefits of each route of delivery and without harmful influences on the part of the assistant professional. The doctor-patient relationship when well developed results in a patient's confidence in relation to the physician. In this way, the medical professional for his position holds a great role of influence on the woman[17].

The lack of knowledge about the physiology of childbirth, about forms of pain relief and social influence reinforce the idea that normal childbirth is synonymous with pain and suffering. Causing women to desire for a cesarean section in order to avoid the suffering attributed to normal childbirth.

Intercorrence during childbirth

When asked about occurrences of complications during childbirth, they report as follows:

> No (SUNFLOWER)
>
> No (LILY)
>
> No (ROSE)
>
> No (DAISY)
>
> Yes. Pressure has dropped a lot (TULIP)

The culture of cesarean section normalization provides an evolution of the surgical technique, resulting in better results and attenuation of potential

complications associated with the procedure. Cesarean section for obstetricians is seen as a technological achievement that is often routinely used, even in situations where normal delivery is feasible on the grounds that caesarean section is a safe delivery[18].

With the constant performance of the procedure, physicians feel safe and confident to perform cesarean deliveries even in situations without clinical indication, disregarding the potential risks of both maternal and fetal[18].

Prenatal and delivery follow-up performed in the private network increase the occurrence of cesarean section, however there is a reduction in the possibility of complications when performed by the same professional. In the private network, there is a lower occurrence of complications in cesarean deliveries, although cesarean delivery increases the risk of postpartum complications[19].

Final Considerations

This study aimed to analyze the knowledge about the consequences of cesarean section without clinical indication by women from the private network, and reveals that the orientations are passed differently. Some women had access to the information needed to make their choice, while others, despite respecting the right to choose the route of delivery, were not informed in the full scope of risks and consequences. In view of the particularities of the care provided in the private network, where the medical professional is the main advisor, it is necessary to analyze the level of importance given to access to information by women about indication, maternal and fetal risks and their right to participate effectively in the decision-making process of the choice of the route of delivery.

The study brings a reflection on the relevance of multidisciplinary care where women obtain care centered on women, providing early identification of risks and conditions, and thus collaborating in a safe experience for mother and child.

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Impact of training in first aid on the knowledge of educators and school agents

Impacto da capacitação em primeiros socorros sobre o conhecimento de educadores e agentes escolares

Impacto de la formación en primeros auxilios en el conocimiento de los educadores y agentes escolares

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REVISA

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RESUMO

Objetivo: avaliar o efeito da capacitação em primeiros socorros sobre o conhecimento dos professores e agentes de uma unidade escolar. **Método:** pesquisa quantitativa com delineamento quase-experimental do tipo pré e pós-teste. A população foi constituída por professores e agentes escolares de uma instituição de ensino no interior do Estado de São Paulo. A coleta de dados foi entre os meses de março e abril de 2022, aplicando-se dois instrumentos: Caracterização sociodemográfica/laboral e questionário de avaliação do conhecimento sobre primeiros socorros. Para analisar os dados empregou-se estatística descritiva, teste de Shapiro Wilk e de Wilcoxon. **Resultados:** Predominou o gênero feminino (66,7%), média de idade de 43 anos e 66,7% eram casados. 88,9% não participaram de disciplinas em primeiros socorros na formação e 94,5% afirmaram ter presenciado situações acidentes na unidade escolar. Houve aumento no número de acertos das questões relativas a primeiros socorros e melhora em relação aos conceitos (excelente, bom, regular e ruim), com aumento na pontuação do pré-teste para o pós-teste em 3,51 pontos e com a comparação significativa (p<0,001). **Conclusão:** Os achados mostram que após a aplicação da capacitação em primeiros socorros com professores e os agentes escolares houve aumento de conhecimento, competências e habilidades para atuação na unidade escolar estudada.

Descritores: Primeiros Socorros; Instituições acadêmicas; Serviços médicos de emergência; Enfermagem.

ABSTRACT

Objective: to evaluate the effect of training in first aid on the knowledge of teachers and agents of a school unit. **Method:** quantitative research with a quasi-experimental design of the pre- and post-test type. The population consisted of teachers and school agents from an educational institution in the interior of the State of São Paulo. Data collection took place between March and April 2022, applying two instruments: Sociodemographic/labor characterization and a questionnaire to assess knowledge about first aid. Descriptive statistics, Shapiro Wilk and Wilcoxon tests were used to analyze the data. **Results:** The female gender predominated (66.7%), mean age was 43 years and 66.7% were married. 88.9% did not participate in first aid courses in training and 94.5% said they had witnessed accident situations at the school unit. There was an increase in the number of correct answers in the questions related to first aid and an improvement in relation to the concepts (excellent, good, fair and bad), with an increase in the pre-test to the post-test by 3.51 points and with the comparison significant (p<0.001). **Conclusion:** The findings show that after the application of training in first aid with teachers and school agents, there was an increase in knowledge, skills and abilities to work in the school unit studied.

Descriptors: First aid; Academic institutions; emergency medical services; Nursing.

RESUMEN

Objetivo: evaluar el efecto de la formación en primeros auxilios en el conocimiento de docentes y agentes de una unidad escolar. **Método**: investigación cuantitativa con un diseño cuasi-experimental del tipo pre y post test. La población estuvo compuesta por docentes y agentes escolares de una institución educativa del interior del Estado de São Paulo. La recolección de datos ocurrió entre marzo y abril de 2022, aplicándose dos instrumentos: Caracterización sociodemográfica/laboral y un cuestionario para evaluar conocimientos sobre primeros auxilios. Se utilizó estadística descriptiva, pruebas de Shapiro Wilk y Wilcoxon para analizar los datos. **Resultados:** Predominó el sexo femenino (66,7%), la edad media fue de 43 años y el 66,7% estaban casados. El 88,9% no participó de cursos de primeros auxilios en formación y el 94,5% dijo haber presenciado situaciones de accidentes en la unidad escolar. Hubo un aumento en el número de respuestas correctas para las preguntas relacionadas con primeros auxilios y una mejora en relación a los conceptos (excelente, bueno, regular y malo), con un aumento en el puntaje del pre-test para el post-test en 3.51 puntos y con la comparación significativa (p<0,001). **Conclusión**: Los hallazgos muestran que luego de la aplicación de la formación en primeros auxilios con los docentes y agentes escolares, hubo un incremento en los conocimientos y habilidades y destrezas para el trabajo en la unidad escolar estudiada.

Descriptores: Primeros auxilios; Instituciones académicas; servicios médicos de emergencia; Enfermería.

ORIGINAL

Introduction

Children and adolescents of school age are more vulnerable to suffering such health problems, due to their own physical, behavioral and developmental characteristics.[1]

In the school environment, several activities are carried out, including teaching, research, recreation and socialization, becoming a favorable place for incidents and accidents. Thus, it is not uncommon for teachers to report situations at school that result in cuts, bleeding, sprains and fractures of the upper and lower limbs.[2]

In this sense, authors point out that, in 2017, the number of deaths from external causes (accidents and violence), in the age group from 0 to 19 years old, was 21,559 nationwide; and reflect that many could have been avoided or even minimized.[3]

Other data also indicate that, in Brazil, accidents in the school environment occur more frequently between the age group from 0 to 6 years, reflecting in avoidable epidemiological data from the Ministry of Health, which highlight 158,657 deaths from external causes in childhood in 2017.[4]

In addition to the factors previously presented, school environments have diversified physical structures that can generate accidents, making it difficult to monitor, control and monitor children and adolescents, especially during physical and recreational activities.

The school may have falls-prone locations, such as walls and fences, open culverts and ditches, windows and ramps without railings or protective screens, ladders without railings, and large trees.[5] In this context, it is necessary for teachers and staff to have knowledge to help and assist their student body in situations that require initial care, until the arrival of the specialized health team.[6]

Authors mention that education professionals should receive formal and continued training to face the urgent situations that can happen within the school environment and act providing first aid care.[7]

From this perspective, first aid is considered the immediate assistance provided to an unforeseen individual of health aggravation with or without risk of life, thus aiming to preserve life, relieve suffering, prevent or minimize injuries and promote recovery. This action can be initiated by anyone.[8]

However, due to education-focused training, teachers have incipient knowledge and skills to provide this type of care.[9]

Considering that, in this period of life children and adolescents spend most of their time in school, one should be alert to the possibility of accidents, and above all, it is of fundamental importance the existence of people trained to help.[10,11]

According to the Ministry of Health, while children and adolescents remain in school, it becomes a responsibility of local managers to promote health, develop actions for disease prevention, strengthen protection factors and train their team to act if necessary.[12]

In 2018, Law No. 13,722 was sanctioned, thus making it mandatory throughout the national territory, the training of teachers and employees of basic

education and child recreation with regard to the basic scum of first aid, whether in public or private educational establishments.[13]

The statute of children and adolescents, implemented by Law No. 8,069 of 1990, records that these individuals should "receive protection and help in any circumstances", also guaranteeing him the "right to protection of life and health".[14]

In view of the above, the objective of this study is to evaluate the effect of training in first aid on the knowledge of teachers and agents of a school unit.

Method

This is a quantitative research with a near-experimental design. According to Polit and Beck these studies involve an intervention, however it does not include randomization, not even group-control. It is characterized by the implementation of an intervention and the use of pre- and post-test, with the purpose of comparing before and after the application.[15]

The research was carried out in a public elementary and high school of a municipality located in the interior of the state of São Paulo.

The participants of the research were the teachers and agents of the school active in this educational institution. The inclusion criterion was to be a teacher or school agent and to participate in the two stages of data collection (before and after intervention). The exclusion criteria were to be away for vacation, leave or any other nature during the period of data collection or to be absent in any of the stages of the study (pre-test, educational action, post-test).

The sampling was non-probabilistic and for convenience. According to the criteria listed, of the total of 20 (100%) who comprised the staff, they met the criteria 18, thus constituting the sample of this research.

Data were collected between March and April 2022, in three moments. In the first, the pre-test was used (diagnosis of reality); in the second application of training in first aid (intervention in the face of the demands emerged in the previous stage); and in the latter, the post-test was performed (evaluating knowledge acquisition). All stages occurred in the school environment itself, after scheduling dates with the research participants.

A collection instrument was used divided into two parts: the first containing sociodemographic and work data of professionals and the second consisting of the questionnaire for evaluating the knowledge of teachers and school agents about first aid, elaborated and validated by Cabral and Oliveira.[16]

This questionnaire contains multiple choice questions combined with open questions on the topic of first aid, being: burn, cut, orthopedic trauma, choking/asphyxia, convulsion, intoxication, dental trauma, prickby venomous animals, fainting, cardiorespiratory arrest, electric shock, injury caused by sharp object, hemorrhages, biting and specialized help contact numbers.[16]

The educational action was carried out by applying the problem-based learning methodology, which consists of a "learning method that works with problem situations, previously elaborated by a team of educators, in order to stimulate cognitive processes in relation to a given subject. The problems are carefully planned by a committee with the purpose of integrating theoretical and

practical content, with increasing degrees of complexity." And also, from the demands that will arise after the pre-test.[17]

The data were organized in spreadsheets in Excel and transported to the Real Statistics Data Analysis Tools software, where they were analyzed using statistical techniques.

Initially, the distribution of data was verified by the Shapiro Wilk test, so parametric and non-parametric tests were used depending on the distribution presented by the data. Summary measures (mean and median and standard deviation) were used for descriptive data analysis. In the inferential analysis to compare the effects of pre- and post-test training in the same group of educators and school agents, the Wilcoxon test was used for data with non-symmetric distribution. The level of significance adopted was 5%.

To compare the results of the pre- and post-test, concepts were elaborated according to the number of correct answers of each participant, which were: excellent ≥ to 9 correct answers; good, from 7 to 9 hits; from 4 to 7 hits; bad, ≤ to 4 hits. The goal was set for participants to achieve a minimum of 70% of correct answers in each question in the post-test.

The study was conducted in accordance with Resolutions No. 466 of 2012 of the National Health Council of the Ministry of Health - CNS/MS.18 Once the consent of the institution has been obtained, the project was registered in the Brazil Platform, and submitted for consideration by the Research Ethics Committee, and after obtaining the favorable opinion no. 5,307,727 on March 23, 2022 and CAAE 56356322.9.0000.5431, data collection began.

Results

The findings involved 18 professionals who worked in the research scenario. The response rate corresponded to 100%, both before and after the test.

Regarding the sociodemographic and work characteristics of teachers and school agents, it was found that the mean age was 43 years (SD=24.9), median of 41.5 years, ranging from 38 to 54 years; most were female (12 – 66.7%), 66.7% were married, 94.4% of the professionals completed higher education and 44.4% had graduate degrees. Regarding the time of formation, the mean was 18 years (SD=8.27), ranging from 3 to 33 years.

Regarding work characteristics, it was found that, regarding the position/function, 11 (61%) acted as teachers and 7 (39%) as school agents).

Regarding the experience of working in teaching modalities, 11.1% of the participants taught in early childhood education, 22.2% in elementary school I, 77.8% in elementary school II, 50% in high school and 38.9% in other levels of education (higher education, technical education, youth and adult education, and special education).

Regarding the availability and participation of first aid discipline during the training period, 50% reported not having attended, 11.1% participated in a discipline on the subject in undergraduate studies and 5.6% in graduate school.

Equivalent to extracurricular training in first aid, 88.9% did not perform and 11.1% took a course on the subject. It is also emphasized that 33.3% attended lectures on the subject in the work environment.

Regarding having witnessed some first aid situation in the school unit, 94.5% of the professionals stated that they had seen this occurrence. Regarding the type of urgency witnessed, in which it required action in this context, figure 1 shows.

Figure 1 - Distribution of the frequencies of responses of teachers and school agents, about the type of emergency situation experienced in the school unit, São Paulo, 2022.

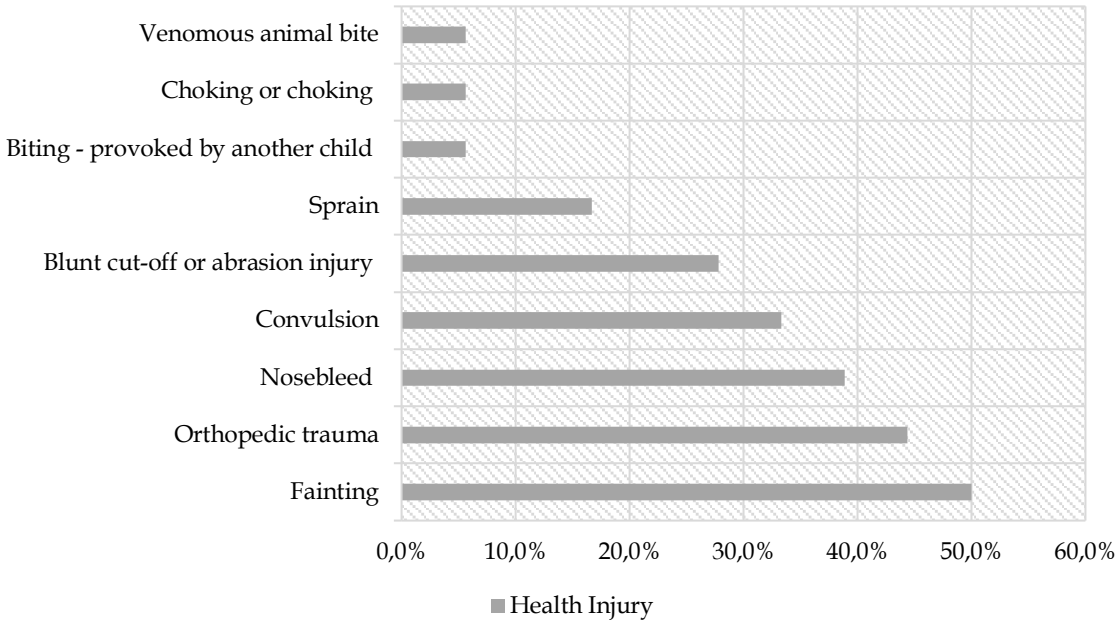

Figure 1 shows that, the most common experiences in the school unit were: fainting (50%), orthopedic trauma (44.4%), nasal bleeding (38.9%), convulsion (33.3%), blunt cut injury or abrasion (27.8%), sprain (16.7%), biting – caused by another child (5.6%), choking or choking (5.6%), and venomous animal bite (5.6%).

When analyzing the pre-test responses, it can be verified that 100% of the participants recognized the importance of performing training on first aid performance in the school environment.

Table 1 shows the findings regarding the application of the pre- and post-test training with teachers and school agents about first aid care.

Table 1 - Distribution of the percentage of correct answers of teachers and school agents, according to pre- and post-test in a school unit. São Paulo, 2022.

Concept	Pretest		Post-test	
	Correct answers		Correct answers	
	N	%	N	%
Excellent	2	11,1%	7	38,8%
Good	4	22,2%	11	61,1%
Regular	11	61,1%	0	0
Poor	1	5,5%	0	0

There was improvement in relation to the concepts, since in the post-test the good and excellent concepts presented a percentage increase and the regular and bad concepts had zero percentage.

Table 2 shows the distribution of the percentage of correct answers for each thematic question in first aid.

Table 2 - Distribution of the percentage of correct answers related to the statements in the pre- and post-test of teachers and school agents of a primary and middle education unit. São Paulo, 2022.

Statement	Theme of statement	Pretest		Post-test	
		Correct answers		Correct answers	
		N	%	N	%
Q1	Burn	17	94,4%	18	100%
Q2	Blunt cut injury or abrasion	15	83,3%	18	100%
Q3	Orthopedic trauma	6	33,3%	17	94,4%
Q4	Choking or choking	11	61,1%	18	100%
Q5	Nosebleed	5	27,8%	15	83,3%
Q6	Seizure	13	72,2%	18	100%
Q7	Intoxication	14	77,8%	18	100%
Q8	Dental trauma	13	72,2%	15	83,3%
Q9	Venomous animal bite	11	61,1%	17	94,4%
Q10	CPR	14	77,8%	17	94,4%

When analyzing the results of table 2, in the pre-test it was possible to verify that the questions with the highest number of correct answers were about burns (94.4%) and cut injury or abrasion (83.3%). The statements concerning orthopedic trauma (33.3%) and nasal bleeding (27.8%) presented a lower percentage.

There was an increase in the number of correct answers after the application of training in first aid care, with emphasis on nasal bleeding obtaining reach of 83.3%, orthopedic trauma 94.4%, choking or asphyxia 100% and prick ing of venomous animal 94.4%.

As for the results of the test applied to compare the effects of pre- and post-test training in the studied group, table 3 is described.

Table 3 - Wilcoxon test results. Sao Paulo, 2022.

Statistical test	N	Z	p
Post-test – Pretest	18	3,51	0,001

We observed from the results of table 3 that there was an increase in the score from pre to post-test by 3.51 points and the comparison of sums was significant with p< 0.001.

Discussion

This research had an expressive participation of the participants, comprising 100%. We highlight the engagement and involvement of the professionals of this service, regarding the proposal of this study.

Regarding sociodemographic variables, the presence of adult professionals was found (mean of 43 years; SD=24.9) ranging from 38 to 54 years and the majority represented by women (66.7%). The findings of this research are analogous to those found in the studies carried out in school units in the states of São Paulo and Rio Grande do Sul, with prevalence of the female population.[2,3,19]

Alusive to feminization among education professionals, this evidence corroborates the historical and cultural aspects of society that recognizes women as born educators, associating with their maternal role. They also add that, currently the presence of male professionals in educational institutions remains low – practically non-existent – in relation to the number of women.[20]

Regarding age, it is observed that the studies showed that most professionals had a mean age between 35 and 45 years.[2,3,19]

Regarding education, the majority had completed higher education (94.4%), however, 8 (44.4%) had specialization in the area. Similar results were found when observing that, of the 63 (100%) education professionals of two schools in Belo Horizonte, Minas Gerais, 77% had graduate degrees.[21]

Regarding the work characteristics, it is noted that, time of experience in the school unit obtained an average of 18 years (SD=8.27). On the other hand, the qualitative study conducted in a school in a municipality of Rio Grande do Sul identified that professionals had an average of 8.5 years of work experience. [22]

In this same study, stratified by the professional categories investigated, the school managers were in the current function between five months and 4 years, all of which had previous experience as a teacher. Teachers had more time in different schools. The most recreational and monitoring professionals were the categories with the longest time in the unit, corresponding between 6 and 10 years.[22]

In this research, it was observed that 50% of the participants did not attend any first aid course during graduation, 94.5% said they had witnessed first aid situations in school and 100% recognized the importance of training in this theme.

These findings are similar to those found in a national study involving education professionals. The authors reveal that 77.8% of the participants

reported not having had a course on the subject, 71.1% reported having witnessed accidents in the school unit that required relief actions.[19]

Authors developed a survey of 52 professionals in an educational center in João Pessoa, Paraíba, most of the interviewees reported not knowing exactly how to proceed in the face of some types of accidents, because they did not have any specific training and adequate to care for the victim[20].

Another investigation, conducted by Cabral and Oliveira, of the 31 participants, 22 stated that they had already experienced situations of accidents at school that required knowledge about the subject and 71% experienced a situation that required immediate action.[23]

In the curriculum of undergraduate courses, with few exceptions, there is no present discipline that teaches basic first aid procedures; consequently, teachers do not know how to act in situations that compromise the child's health, generating risk to the vital state of the school.[5]

Regarding the types of occurrences seen in the school environment, teachers and school agents showed fainting (50%), orthopedic trauma (44.4%), nasal bleeding (38.9%) and convulsion (33.3%), as the most frequent injuries.

In this respect, a research identified that the most recurrent injuries pointed out by the participants were allergic crisis, viral symptoms, bites and scratches, choking, falls, abrasions, traumas, bruising, injuries, blunt cuts and nasal bleeding.[22]

However, the other study revealed that teachers feel unprepared to attend to simple situations, have doubts about the severity of injuries, not feeling able to provide care, presenting unsafe attitudes and fear of performing care, without knowing how to identify the best conduct to be taken.[5]

Regarding the results of the pre-test, it was found that the highest percentage of correct answers was related to burns, blunt injury or abrasion and intoxication. In agreement with the studies, which identified a higher percentage of correct answers in these same injuries.[16,19,3]

Considering the application of the training and the results of the post-test, there was an increase of 3.51 points of correct answers after intervention, evidencing that the activities of health education provided the participants with a significant learning with the acquisition of new knowledge.

The near-experimental investigation, carried out in a school unit in the north of the state of Rio Grande do Sul, found that, after the first aid training intervention, the professionals had an average of 11.13% to 19.45% increase in the correct answers of the questions.[3]

Another study applying this same type of methodology showed that there was an increase in the number of correct answers in the statements of 5.17 points, with emphasis on those related to nasal bleeding (from 48.9 in the pre-test to 91.1% in the post-test), hemorrhages (from 51.1 in the pre-test to 88.9% in the post-test), cardiorespiratory arrest (from 13.3 in the pre-test to 51.1% in the post-test) and cut-off or skinning injury (from 53.3% to 86.7%).[19]

Another study also obtained positive results in teaching first aid to teachers, and 37.26% of the interviewees before training were unaware of the actions they could perform or performed incorrect procedures24. After training,

there was an increase to 83.31% regarding the acquisition of knowledge and application of the correct approach.

Training on the theme is presented as a coping strategy to contribute to its safety and make teachers trained/trained. It is pertinent to highlight that this empowerment in first aid in the school context should go beyond the transmission of information about the correct conducts, should include the identification of the risks of accidents and the prevention of these accidents, as well as issues related to the family structure, social roles of parents that are factors that influence the education and risk behavior of schoolchildren.[8]

Authors point out that educational strategies with teachers favor the group to clarify doubts and mititthe insecurity in providing inadequate care with consequent worsening of the victim's condition. However, it is recognized that in addition to educational interventions, accident prevention and safety at school must necessarily consider the adequacy of the physical structure.[5]

Conclusion

This study allowed evaluating the effect of training in first aid on the knowledge of teachers and agents of a school unit in the state of São Paulo.

It was found that most of the participants in the pre-test had insufficient knowledge about the performance in first aid, especially in the diseases related to nasal bleeding, convulsion, orthopedic trauma, venomous animal bite, blunt cut and excoriation and PCR.

After the application of training in first aid, it was noticed that there was an increase in knowledge between teachers and school agents, with significant percentages.

Therefore, the importance of health education is observed, especially in school environments. Emphasizing that, educational actions in first aid should be planned and carried out annually according to the provisions of Law No. 13,722 of 2018.

Thus, it is necessary to encourage the partnership between education and health professionals in order to perform actions in the educational environment, helping to build new knowledge, strategies, skills and skills in to act in first aid situations.

The limitations of this study lie in the sample size, however, it is worth noting the high percentage of participation; realization only in a school unit.

Aknowledgement

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Stress, quality of sleep and quality of life in health students

Estresse, qualidade do sono e qualidade de vida em acadêmicos da área de saúde

Estrés, calidad de sueño y calidad de vida en estudiantes de salud

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REVISA

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RESUMO

Objetivo: Analisar o estresse acadêmico, a qualidade do sono e a qualidade de vida de estudantes da área de saúde. **Método:** Trata-se de um quantitativo, transversal realizado com 34 discentes de da área de saúde de uma faculdade privada de Goiás, via google forms, de novembro a dezembro de 2021 por meio de Formulário para caracterização sociodemográfica e acadêmica e; Instrumento para Avaliação do Estresse em Estudantes de Enfermagem, Índice de Qualidade de Sono de Pittsburgh; e Instrumento de Avaliação de Qualidade de Vida. A análise ocorreu no Statistical Package for Social Sciences (SPSS), versão 20.0. **Resultados:** Verificou-se predomínio alto nível de estresse geral (52,9%), alto estresse nas atividades teóricas (23,5%), muito alto estresse na formação profissional (20,6%) e médio estresse na realização de atividades práticas (20%). Os discentes apresentaram baixa qualidade do sono (79,4%) e moderada(41,2%) e baixa qualidade de vida (35,3%). **Conclusão:** o ambiente acadêmico e suas demandas são percebidos como estressores pelos discentes, principalmente quanto às atividades teóricas, às práticas clínicas e a formação profissional, com impacto negativo à sua qualidade do sono e qualidade de vida.
Descritores: Estresse Psicológico; Estudantes; Qualidade de Vida.

ABSTRACT

Objective: To analyze the academic stress, sleep quality and quality of life of health students. **Method:** This is a quantitative, cross-sectional study with 34 students from health courses from a private college in Goiás, via google forms, from November to December 2021 through a form for sociodemographic and academic characterization and; Instrument for Stress Assessment in Nursing Students, Pittsburgh Sleep Quality Index; and Quality of Life Assessment Instrument. The analysis took place in the Statistical Package for Social Sciences (SPSS), version 20.0. **Results:** There was a predominance of high level of general stress (52.9%), high stress in theoretical activities (23.5%), very high stress in professional education (20.6%) and medium stress in performing practical activities (20%). The students presented low sleep quality (79.4%) and moderate (41.2%) and low quality of life (35.3%). **Conclusion:** the academic environment and its demands are perceived as stressors by students, especially regarding theoretical activities, clinical practices and professional training, with a negative impact on their quality of sleep and quality of life.
Descriptors: Psychological Stress; Students; Quality of Life.

RESUMEN

Objetivo: Analizar el estrés académico, la calidad del sueño y la calidad de vida de los estudiantes de salud. **Método:** Se trata de un estudio cuantitativo, transversal con 34 estudiantes del campo de la salud de un colegio privado de Goiás, vía formularios google, de noviembre a diciembre de 2021 a través de un formulario de caracterización sociodemográfica y académica y; Instrumento para la Evaluación del Estrés en Estudiantes de Enfermería, Pittsburgh Sleep Quality Index; e Instrumento de Evaluación de la Calidad de Vida. El análisis tuvo lugar en el Statistical Package for Social Sciences (SPSS), versión 20.0. **Resultados:** Predominó el alto nivel de estrés general (52,9%), el alto estrés en las actividades teóricas (23,5%), el estrés muy alto en la educación profesional (20,6%) y el estrés medio en la realización de actividades prácticas (20%). Los estudiantes presentaron baja calidad de sueño (79,4%) y moderada (41,2%) y baja calidad de vida (35,3%). **Conclusión:** el entorno académico y sus demandas son percibidos como factores estresantes por los estudiantes, especialmente en lo que respecta a las actividades teóricas, las prácticas clínicas y la formación profesional, con un impacto negativo en su calidad de sueño y calidad de vida.
Descriptores: Estrés Psicológico; Estudiantes; Calidad de vida.

ORIGINAL

Introduction

Academic life is somewhat challenging in itself. In addition to being a new stage of life totally different from the school phase, it requires a remarkable physical and mental effort in view of the new level of education, changes in responsibilities and academic requirements. For health students, it becomes more complex because of the responsibility involved in human care.[1-2]

Thus, the university routine is usually stressful and exhausting by academic demands, such as: work, tests, seminars, internships, reports, extension projects, and others. All these obligations require intense diligence of the student to acquire the maximum knowledge to apply in their respective area of activity and not to make crucial mistakes the patient's life that can lead to irreversible situations or even death. In view of these aspects, it is possible for the student to evaluate academic situations as stressful throughout the course.[3]

In this context, stress is defined, starting from the interactionist model, as any stimulus that demands from the external or internal environment and that taxor exceeds the sources of individual adaptation or social system.[4] Studies on academic stress in the health area point to the student's susceptibility to return mental and physical health changes, such as: depression, anxiety, stress, fear, insecurity, changes in sleep pattern and quality, self-exclusion from their social and family cycle, among others. The result is perceived throughout the graduation due to social and family leave, as well as changes in routine and a fall in income and participation of students in classes, which directly implies student learning.[1-3]

Sleep quality among students is very important because sleep influences every performance when you are on waking. When you have a complete night's sleep in which you can sleep REM, the whole body resets the energies of daily wear, our central nervous system goes into total relaxation, causing decreased body temperature, the production and release of hormones and the fixation of information and memories acquired throughout the day, which is important to the intellect and humor development of the human being. Changing sleep standards and quality lead to harm, such as: lower concentration capacity, difficulties in performing tasks and planning them, with an impact on the student's quality of life.[5]

The quality of life of university students in the health area is currently related to self-esteem, conduct capacity, economic situation, integral health and emotional status. The sum of the various factors, such as the form of transport used up to the HEI, the study shift (Morning or Night), leisure time in family and friends environment, the workload studied during the semester, financial difficulties and financial conditions, can impact the student's quality of life, both in environmental areas, psychological and social relationship.

Based on the above, it is verified that the student of the health area lives an academic reality that can lead to stress, with impact on quality of sleep and quality of life.[6-7]

In this sense, the aim of this study was to analyze the stress, quality of sleep and quality of life of health students throughout the course.

Method

This is a quantitative, cross-sectional and descriptive study with 34 students from health courses of a private college in the state of Goiás. Students regularly enrolled in all stages of undergraduate courses belonging to the health area (nursing courses, pharmacy and physiotherapy) of all institutions and over 18 years of age were included. Those who participated in the research as data collection assistants were excluded; and that, during the data collection period, they were in exchange.

Data were collected from November to December 2021, via google forms, through the following instruments: Form for sociodemographic and academic characterization; Instrument for Stress Assessment in Nursing Students (ESA), Pittsburgh Sleep Quality Index (IQSP) and Quality of Life Assessment Instrument (WHOQOL-Bref). After obtaining the e-mail addresses of the students enrolled in the health courses from the 1st to the 8th semesters, the Informed Consent was sent and invited to the students for the research. After the acceptance and online signature of the TCLE, an e-mail was sent with the link to access the data collection protocol, with a period of ten days of completion of the same.

The Form for characterization included the following sociodemographic variables: date of birth, sex, children, marital status, with whom he/she resides, performing leisure activities, sports, sports, income sources, financial dependent, sufficiency of monthly income for maintenance, use of drug or substance (tea, coffee, energy, etc.) to inhibit sleep and to be able to sleep; smoking and alcohol consumption; and academic: time spent to reach HEI, means of transportation, workload in the current semester, performing extracurricular activities, work activity, professional experience in the health area, satisfaction with the course and interest in giving up the course.

The Instrument for Stress Assessment in Nursing Students (ESA) was proposed by Costa and Polak in 2009[2] and consists of 30 items grouped into six domains: Performance of practical activities (Items 4,5,7,9,12 and 21); Professional communication (Items 6,8,16 and 20); Time management (Items 3,18,23, 26 and 30); Environment (Items 11,22,24 and 29); Vocational training (Items 1,15,17,19,25 and 27); Theoretical activity (Items 2,10,13,14 and 28). The items are presented in a four-point likert scale in which: zero - "I do not experience the situation"; one- "I don't feel stressed about the situation"; two - "I feel little stressed about the situation"; and three- "I feel very stressed about the situation[2]. To identify the stress intensity by ESA factor, risk quartiles were used, as shown in Figure 3.

The Pittsburgh Sleep Quality Index (IQSP) was validated in Brazil by Bertolazi.8 and applied to Brazilian university students.9 In this instrument there are ten questions: question one to four- open; and five to 10- semi-open. These questions are distributed in seven components, as follows: Subjective sleep quality (Question 6); Sleep latency (Questions 2 and 5a); Sleep duration (Question 4); Habitual sleep efficiency (Questions 1, 3 and 4) Sleep disorders (Questions 5b up to 5j); Use of sleeping medications (Question 7); daytime sleepiness and disturbances during the day (Questions 8 and 9). Question ten is of optional use

and will not be applied in this research, since it requires the presence of a roommate for your analysis.[8]

The overall score is generated by the sum of the score of each component, which has a weight ranging from 0 to 3. Thus, the maximum possible value is 21 points, and the more this score, the worse the quality of sleep. Scores higher than five points indicate poor quality in sleep pattern. For the conversion of the answers obtained in each question to a likert scale, the instructions described next to the instrument in a research with health professionals will be followed.[10]

The WHOQOL-BREF, elaborated by the WHO, was validated for Portuguese in 1998[11], being a generic instrument for measuring quality of life (QOL). It is an instrument composed of 26 items, among which: two open questions about quality of life and 24 items on a five-point Likert scale (1 - 5). The 24 items are distributed in four domains that denote an individual perception of quality of life for each particular facet of QOL, namely: Physical, Psychological, Social Relations and Environment.[11] The other two items are evaluated separately, so that: Item 1 denotes the individual's perception of his/her QoL; and Item 2 assesses its perception of satisfaction with your health.[11] For WHOQOL-Bref analysis, items 3, 4 and 26 should have their scale inverted as follows: 1=5; 2=4; 3=3; 4=2; 5=1. After this process, we must calculate the mean per domain, obtained by the sum of the scores attributed to each item of the domain and divided by the number of items that make up the domain.[11] In order for the WHOQOL-BREF scores to be comparable to those of the WHOQOL-100, the mean of each domain must be multiplied by 4. For the analysis of general quality of life, the average of all items per individual should be performed. The higher the scores obtained in the domains and in the general evaluation, the higher the quality of life presented by the subject.[11]

For data organization and analysis, a database was created in the Excel program (Office 2010) and the Statistical Package for Social Sciences (SPSS, version 20.0) program was used. The qualitative variables will be presented in absolute (n) and percentage values (n%). Quantitative variables will be exposed in descriptive measures: minimum and maximum values, mean and standard deviation. Cronbach's alpha will be applied to analyze the reliability of the applied instruments.

In compliance with the Guidelines and Regulatory Standards of Research Involving Human Beings (RESOLUTION CNS 466/12), this project was submitted to the Research Ethics Committee (CEP) of the private higher education institution of the state of Goiás, having been approved on July 13, 2020 under opinion number 4,151,512.

Results

The initial study population consisted of 215 students from health courses (Nursing, Pharmacy and Physiotherapy), and 34 students agreed to participate in the research and composed the access population of this research. Table 1 shows the sociodemographic and academic data (Categorical variables) of health students.

Table 1- Sociodemographic and academic data (Categorical variables) of students in the health area (n=34). Goiás, 2022.

Variable	Category	n	%
Gender	Female	27	79,4
	Male	7	20,6
Marital Status	Married	11	32,4
	Divorced	2	5,9
	Separate	3	8,8
	Single	18	52,9
Children	No	18	52,9
	Yes	16	47,1
Who do you live with?	Family	30	88,2
	Other	1	2,9
	Alone	3	8,8
Sports Practice	No	24	70,6
	Yes	10	29,4
Leisure Practice	No	13	38,2
	Yes	21	61,8
Source of Income	Paid Internship	3	8,8
	Other	5	14,7
	Family resource	9	26,4
	Fixed Work	17	49,9
	Total	34	100
Responsible for maintenance	Didn't answer	6	17,6
	Parents	14	41,1
	Other	14	41,2
Sufficient Monthly Income	No	20	58,8
	Yes	14	41,2
Do you use drugs to inhibit sleep?	No	27	79,4
	Yes	7	20,6
Do you use sleeping drugs?	No	31	91,2
	Yes	3	8,8
Do you have a habit of smoking?	No, I've never smoked.	32	94,1
	Yes, I smoke.	2	5,9
Do you drink alcohol?	No, I've never had a drink.	17	50
	No, I stopped	1	2,9
	Yes, I drink	16	47,1
Means of transport	Car	22	64,7
	Car and Bus	1	2,9
	Bus	11	32,4
Work	No	23	67,6
	Yes	11	32,4
Health experiences	No	17	50
	Yes	17	50

	Total	34	100
Are you satisfied with the course?	No	2	5,9
	Yes	32	94,1
Have you thought about dropping out of school?	No	19	55,9
	Yes	15	44,1

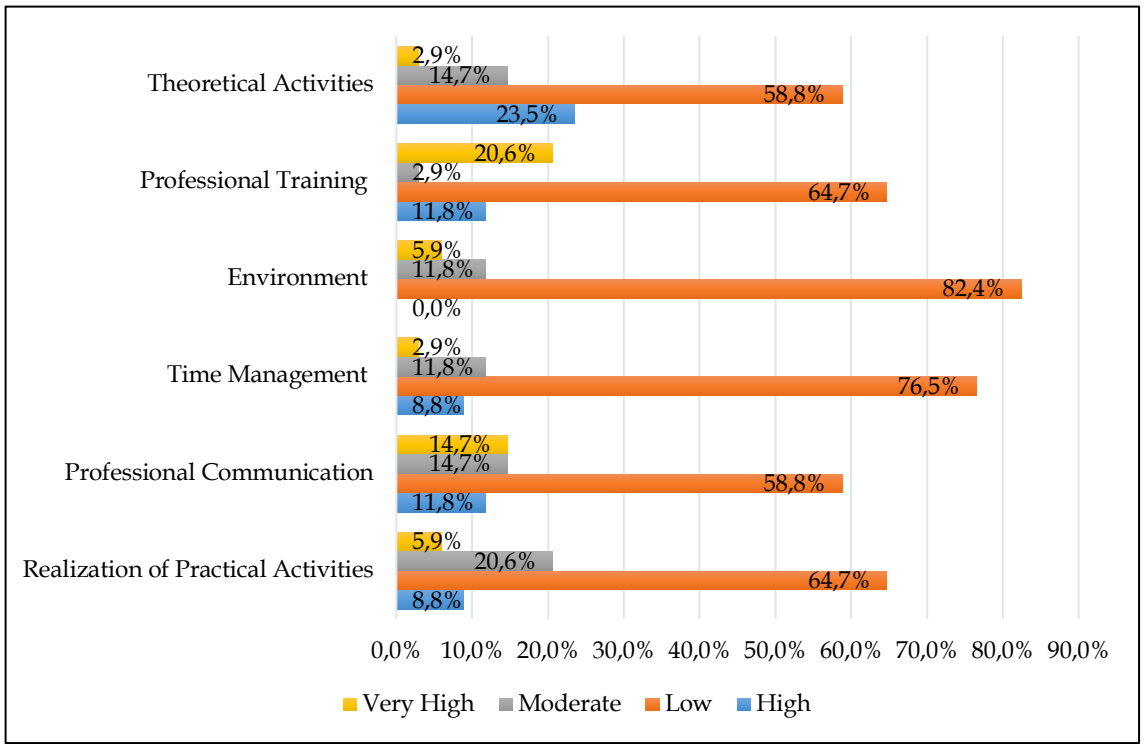
Above, there is a predominance of female students (79.4%), single (52.9%), without children (52.9%) who live with their families (88.2%), who have steady work as a source of income (49.9%) and parents as responsible for financial maintenance (41.1%), with 58.8% stating that the monthly income is not enough to maintain. Besides, 70.6% do not practice sports and 61.8% do leisure activities, 79.4% use medication to inhibit sleep, 47.1% have the habit of drinking alcohol, 5.9% have the habit of smoking, 50% have previous experience with the health area, 94.1% are satisfied with the course and 44.1% have thought about giving up the course at some point. Table 2 shows the sociodemographic and academic data (Continuous variables) of health students.

Table 2- Sociodemographic and academic data (Continuous variables) of students in the health area (n=34). Goiás, 2022**.**

Variable	Minimum	Maximum	Mean	Median	Standard Deviation
Age	17	47	29,1	29	8,26
Time to reach the Educational Institution (minutes)	5	120	28,4	20	25,10

It is observed in the table above that the students have an average age of 29.1 years (SD: 8.26 years) and take, in median, 20 minutes to reach the educational institution (SD:25,10). Figure 1 shows the distribution of students according to the levels of stress per domain of the ESA

Figure 1- Distribution of students according to stress levels by AEEE domain. Goiás, 2022.



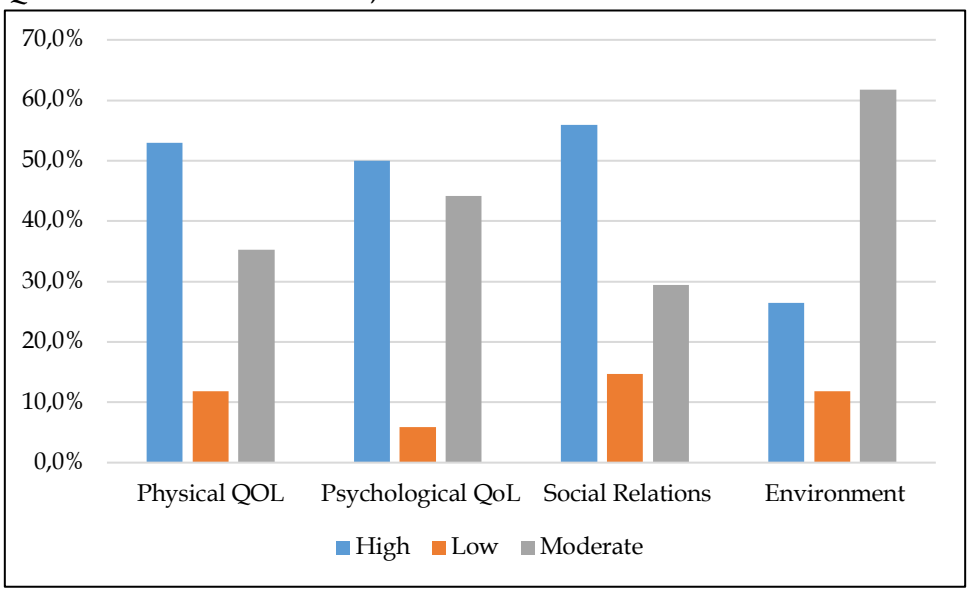
We can see above that there was a predominance of low stress in all domains of the instrument. Despite this, the occurrence of high stress in theoretical activities (23.5%), very high stress in professional training (20.6%) and medium stress in carrying out practical activities (20%) stands out. Table 3 shows the distribution of students according to general stress levels, sleep quality and quality of life.

Table 3- Distribution of students according to general stress levels, sleep quality and quality of life. Goiás, 2022.

Variable	Level	n	%
General Stress	High	18	52,9
	Low	16	47,1
Sleep quality	High	7	20,6
	Low	27	79,4
Quality of life	Low	12	35,3
	Moderate	14	41,2
	High	8	23,5

Above, there is a predominance of students with a high level of stress (52.9%), low quality of sleep (79.4%) and moderate quality of life (41.2%), followed by those with low quality of life (35.3%). Figure 2 shows the distribution of students according to levels of quality of life by WHOQOL-BREF Domain.

Figure 2- Distribution of students according to quality-of-life levels by WHOQOl-BREF Domain. Goiás, 2022.



Above, the predominance of students with high physical quality of life (52.9%), psychological (50.0%) and related to Social Relations (55.9%) can be observed. On the other hand, the quality of life related to the Environment was predominantly moderate (61.8%).

Discussion

There was a predominance of female students (79.4%), single (52.9%), no children (52.9%), who live with their families (88.2%), who have fixed work as a source of income (49.9%) and parents responsible for financial maintenance (41.1%), and 58.8% say that monthly income is not sufficient for maintenance.

It is known that studies indicate that health students, predominantly in the current literature, refer to females. As is perceived in the research under discussion.[12]

Researchers report that the quality of life of university students in the health area is currently related, among other factors, to economic issues [5,6]. The study highlights that 58.8% when reporting that monthly income is not sufficient for maintenance, it becomes something worrisome for Qol.

Authors point out that the uncertainties regarding the conditions of living with the costs of college, the insertion in the labor market and the realization and professional satisfaction at the end of the graduation in health, corroborates the emergence of anxiety and inner suffering feelings, so many students want to take advantage of all available opportunities, however, by not achieving balance in student life, students end up having an overload in their social and family life, a fact that can generate stresses at various levels.[13]

Moreover, it was observed that 70.6% do not practice sports and 61.8% do leisure activities, 79.4% use medications to inhibit sleep, 47.1% have the habit of drinking alcohol, 5.9% have the habit of smoking, 50% have previous experience with the health area, 94.1% are satisfied with the course and 44.1% have already

thought about dropping out of the course at some point. Table 2 shows the sociodemographic and academic data (Continuous variables) of health students.

Changing sleep standards and quality lead to harm, such as: lower concentration capacity, difficulties in performing tasks and planning them, with an impact on the student's quality of life.[5]

The use of medications to inhibit sleep, the habit of drinking and smoking, among other aspects collected in the research, has in the scientific literature, a basis for such attitudes, because authors highlight that university students are often subject to varied times of studies due, always with overload of educational tasks, besides having to manage personal life, and family with school exercises and exams. Thus it is noticeable that the need to meet these commitments compromises sleep, causes daytime sleepiness and increases the risk of stresses.[12]

It was observed that the students have an average age of 29.1 years (SD: 8.26 years) and take, in median, 20 minutes to reach the educational institution (SD:25,10). Figure 1 shows the distribution of students according to the stress levels per Domain of the ESA.

The results of Figure 1 are consistent with several authors, in the item that highlights that in the analysis of the data obtained in the research, in relation to the domain of the ESA instrument, it is found that the domain on the performance of practical activities aimed at performing procedures that end up guide the level of stress of the students.[14,15,12] Regarding the stress assessment scale, it is worth mentioning that this pathology is defined, starting from the interactionist model, as any stimulus of external or internal environments interfering in the adaptation of people to social life.[4]

In the comparations between the stress levels in the research, there was a predominance of low stress in all domains of the instrument. Nevertheless, we highlight the occurrence of high stress in theoretical activities (23.5%), very high stress in professional education (20.6%) and medium stress in performing practical activities (20%). Table 3 shows the distribution of students according to the levels of general stress, quality of sleep and quality of life.

As health students at a higher level have an excessive burden of subjects to attend and at the end of the course supervised internships, researchers recognize that the student during his course is in front of many activities, interfering in the quality of sleep and life, thus becoming a potential patient for the involvement of stresses.[16, 17]

The predominance of students with high stress level (52.9%), low sleep quality (79.4%) and moderate quality of life (41.2%) was identified, followed by those with low quality of life (35.3%). Figure 2 shows the distribution of students according to quality-of-life levels by WHOQOl-BREF Domain. According to authors who deal with the relationship stresses and academic life, there is a consensus that there are three distinct phases of stress, the first being the alert phase, the second to the resistance phase and the third phase of exhaustion which are differentiated by a set of characteristic symptoms.[18, 19]

The research in question highlights that 52.9% of the students are in the Exhaustion Phase, and this factor is seen as something in relation to this pathology. As for low quality of life having an index of (35.3%), this data deserves attention on the part of scholars in the area, because QoL can be a complex process, because it involves subjective aspects, among health students

who live intensely objectively, concerned with happiness, love, pleasure and full personal and professional fulfillment.[15, 20]

The predominance of students with high quality of physical life (52.9%), psychological (50.0%) and related to Social Relations (55.9%) was attested. On the other hand, the quality of life related to the Environment was predominantly moderate (61.8%). Studies indicate that stress is caused by a psychological, environmental or physiological stimulus, seen as a threat to the balance of the organism that is in a situation of physical and emotional effort,[21] this statement is consistent with the results obtained in this research.

Conclusion

There was a predominance of students with a high level of general stress (52.9%). In the analysis of this phenomenon according to the domains of the ESA, high stress was observed in theoretical activities (23.5%), very high stress in professional education (20.6%) and medium stress related to the performance of practical activities (20%). In addition, it was observed that students have low sleep quality (79.4%) and moderate quality of life (41.2%), followed by those with low quality of life (35.3%).

It is observed that the academic environment and its demands are perceived as stressful by the students, especially with regard to the demands of theoretical activities throughout the course, to clinical practices, including internships and laboratory class, as well as with the future professional after the end of the course. In this context, students develop low sleep quality and lower quality of life.

Aknowledgement

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Life story of ex-prisoners

História de vida de egressas do sistema prisional

La historia de vida de los ex presos

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REVISA

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RESUMO

Objetivo: Relatar o desenvolvimento do trabalho de campo com uso do método história de vida com mulheres egressas do sistema prisional do Distrito Federal e RIDE (Região Integrada de Desenvolvimento Econômico). **Método:** Trata-se de relato de experiência enfatizando os aspectos dessa vivência por meio de ferramentas originárias de estudos do método história de vida. Apresentam-se os caminhos adotados ao longo do desenvolvimento da coleta, registro e análise das informações, utilizando a observação participante e entrevista clínica. Seguiu-se o padrão cíclico do método proposto por Gaulejac, no qual os dados obtidos foram repetidamente aprofundados por outras observações e análises. **Resultado: A**s técnicas utilizadas mostraram-se valiosas para a revelação psicológica. **Conclusão:** As vivências na entrevista clínica foram momentos ricos em aprendizado e investigação, percebendo a amplitude da influência que as dimensões psicossociais têm no cotidiano e comportamentos humanos. O desenvolvimento da habilidade do olhar da psicologia social pode aperfeiçoar as práticas de saúde.
Descritores: Pesquisa em Psicologia; Egressos do sistema prisional; História de vida.

ABSTRACT

Objective: To report the development of fieldwork using the life history method with women from the prison system of the Federal District and RIDE (Integrated Region of Economic Development). **Method:** This is an experience report emphasizing the aspects of this experience through tools originating from studies of the life history method. The paths adopted throughout the development of information collection, recording and analysis are presented, using participant observation and clinical interview. The cyclic pattern of the method proposed by Gaulejac was followed, in which the obtained data were repeatedly deepened by other observations and analyses. **Results:** The techniques used proved to be valuable for psychological revelation. **Conclusion:** The experiences in the clinical interview were moments rich in learning and research, realizing the extent of the influence that psychosocial dimensions have on daily life and human behaviors. The development of the ability of the social psychology look can improve health practices.
Descriptors: Research in Psychology; Ex-prisoners; Life's history.

RESUMEN

Objetivo: Informar sobre el desarrollo del trabajo de campo utilizando el método de historia de vida con mujeres del sistema penitenciario del Distrito Federal y RIDE (Región Integrada de Desarrollo Económico). **Método:** Este es un informe de experiencia que enfatiza los aspectos de esta experiencia a través de herramientas que se originan en estudios del método de historia de vida. Se presentan los caminos adoptados a lo largo del desarrollo de la recolección, registro y análisis de la información, utilizando la observación participante y la entrevista clínica. Se siguió el patrón cíclico del método propuesto por Gaulejac, en el que los datos obtenidos fueron profundizados repetidamente por otras observaciones y análisis. **Resultados:** Las técnicas utilizadas demostraron ser valiosas para la revelación psicológica**. Conclusión:** Las experiencias en la entrevista clínica fueron momentos ricos en aprendizaje e investigación, dándose cuenta del alcance de la influencia que las dimensiones psicosociales tienen en la vida cotidiana y los comportamientos humanos. El desarrollo de la capacidad de la mirada de psicología social puede mejorar las prácticas de salud.
Descriptores: Investigación en Psicología; Ex presos; Historia de vida.

ORIGINAL

Introduction

People constantly use a complex system of meanings - which constitutes their culture - to organize their behavior and understand the world in which they live. As subjects, they carry with them their historicity. For the perspective of psychosociology and clinical sociology, the subject is understood as a social being. The concept of social subject brings together a dimension of intersubjectivities, which is constituted from family and social relationships. "As a subject, he participates in the elaboration of a meaning and a collective identity that, in return, feeds its uniqueness." [1] The concept of social subject brings together a dimension of intersubjectivities, which is constituted from family and social relationships. "Each member, as a subject, participates in the elaboration of a meaning and a collective identity that, in return, feeds its singularity".1 The psychic questions that individualize and place it as a multidetermined subject are fundamental and structuring points.".[1-2]

On the other hand, historicity, in turn, can be understood as the way the subject means, recognizes his history and is able to act in it, establishing strategies that are legitimized by culture and socioeconomic condition; is the tension that is established between reproduction and innovation; it is in this interval that the subject builds his historicity.[3] The articulation between these two dimensions is indispensable, because taking into account only the psychic dimensions would be to blame the subject and place him helplessly before his history.

On the other hand, the social determinants analyzed in isolation do not correspond to the power of meanings that the subject can attribute to his own history. After exposition of the way psychosociology and clinical sociology are structured and understood the phenomena related to the subject and its historicity, these approaches from different areas of knowledge lead to the use of theoretical foundation according to the methods and results to be obtained.

When it comes to the method, life history or life report, in turn, it establishes the strategies of data collection of man in the context of social relations and is committed to the process of recollection and reconstruction of the experience lived by the subject.[4] The account of the life story does not correspond to the objective description of the lived, but to the act of telling the very story that takes place in the construction and reconstruction of a person's life.[5] From the countless situations experienced and the meanings attributed by each one, it allows the researcher to know the intertwinings and tensions between the lived, the acquired and the imaginary. In this sense, there is no prerogative of veracity of the facts. It is understood, however, that the way the subject seized the lived enables access to its symbolic, relational universe and its social context.[6-10]

The process of narrating allows the subject to construct other perspectives about his past, present and future, being able to appropriate his own life history, understanding the intersystemic determinations related to psychological, social and historical aspects and, from this, makes it possible to modify the paths that were traveled in his personal trajectory.[11] Knowing your history and being aware of it can be a path to personal development.

Life histories allow three different perspectives, they are: positions occupied from professional socio-professional indicators; individual and family

events that influenced the trajectory and historical transformations that interfered in the subject's trajectory.[3] The subject, when narrating his life history, can reflect, reformulate and transform his previously defined destiny, as well as situate his life history in the socio-historical context of those who tell it.[2,12] "The autobiographical method allows us to understand the dialectical circularities between the universal and the singular, between the objective and the subjective, between the general and the particular".[12]

These investigations bring contributions to the performance of psychologist professionals, considering the elements of a given reality, and produce new knowledge from the perspective of the actors involved.

With regard to the population of women egr. in the prison system, in addition to the specific perspective established through the method, there is a scarcity of production in the scientific literature on the subject.[13-14]

Data from national surveys show that female incarceration has increased dramaticly in Brazil. The "Thematic Report on Women Deprived of Liberty", of the National Survey of Prison Information (INFOPEN Women) of 2017, points out that, in the first half of that year, the number of women incarcerated corresponded to 37,828 nationwide. According to data from the 2014 report, between 2006 and 2014, the female prison population increased by 567.4%, while the male prison population, 220%, placing Brazil in the position of the fifth female prison population in the world.[15-17] This alone is an alarming fact, considering that only 7% of the prisons in the country are female and 18% are mixed, even with the provision of Law No. 7,210 of July 11, 1984, which guarantees the separation of female and male prisons.[17]

Statistical data are permeated by other issues that point to the complexity of the situation. Of the women incarcerated, 50% are young, considering the age group between 18 and 29 years, and 21% are in the age group between 40-45 years. Have low schooling, 68% are black and 62% are serving time for drug trafficking.[15-16] Drug Law No. 11,343, of August 26, 2006, favored the increase of the female prison population in a significant way, and even exemplifies the number of prisons that have emerged in the last ten years. In the country, there are 1,424 prisons, four out of ten of which are less than ten years old.[15]

One in four women serving time in the Federal District went through the socio-educational system as a teenager and 80% have children out of prison and declare that they have other relatives in prison, with 15% of them partners and 45% of other family members.[18-19] The report "Weave Justice: prisoners and provisional prisoners of the city of São Paulo" also pointed out that 81.2% of women in prison were mothers, and 14.1% had five children or more, and 64% of women in prison were responsible for the support of their family.[20] Over the years, women have ceased to occupy a secondary position with regard to incarceration and, around the 2000s, Brazil began a change in the profile of incarcerated people, experiencing a phenomenon that can be called feminization of prisons.[18] This same phenomenon was observed in European countries in previous periods and in Latin America in a period analogous to that of Brazil.

With regard to the level of education, despite the low schooling found in the group of women in the execution of sentence, they still have higher education

than men in similar situation and 25% of women in penalty are involved in some activity related to educational and/or professional training.[16]

The Brazilian data are in line with the Scenario of Latin America where, in 2011, 94% of the women arrested were mothers and had on average three children and 63.5% were the main source of income for the family.[21] In addition, discussing the issue of imprisoned women requires observing some aspects, it is a system in which there is a lack of public policies that guarantee basic rights, women are a public mostly forgotten in the prison system, there are issues related to gender, social inequality, collective health and human rights, which accentuate the processes of suffering from the reality of the women who go through the condition of incarated.[22]

The historical trajectory of women as a social subject is marked by subordination in the private field and invisibility in public spaces and even with the transformations of the logic of capital and the new social roles that women began to occupy in society, patriarchal mechanisms still prevail in relationships, such aspects reverberate in the prison experience, it is also highlighted that by becoming important the stigmatization suffered by women is tied to sexist conditions that generate feelings of self-blaming, failure and submission.[23]

Prison conditions constitute human rights violations and incarceration has consequences for women and their families, both with regard to bonds and the capacity to sustain and social reintegration.[24]

The consequences of the criminal penalty extend to family members and the group of peers and have psychological, social and economic effects (Cabral & Medeiros, 2015). Goffman (2004) states that stigma spreads in decreasing waves to family members in the institutional environments they attend. The concept of stigma is directly related to the construction of the subject's identity, and may be linked to a question of body, character, tribe, race or religion, but it is always a derogatory attribute on the moral status of the individual. The author defines stigma as "the situation of the individual who is inbilitated for full social acceptance".[25]

There is a tendency of generalization that is possible to observe in relation to stigma, this mark reduces the individual to his group, without taking into account his identity peculiarities and the differences between the members of the stigmatized group. The stigma and the place of social exclusion around the prisoners are transferred to the family, which causes society to relate to both as if they were just one, and this extends even in the moment of life after prison.[26]

The aim of this article is to report the experience of the authors in conducting and developing fieldwork using the life history method with women who are from the prison system of the Federal District and RIDE (Integrated Region of Economic Development).

The experience report is characterized as one of the important methods in scientific production, especially with regard to the areas that are implied in subjective processes, it has been that it is a theoretical-practical construction based on the experience itself, which is shaped through the look of the subject who researches, in view of its historical and cultural context.[27]

From the perspective of qualitative research, the experience report is delineated as a production that requires processes of memory and implication of

the subject, which was affected by the experience, there is a multiplicity of methodological theoretical options, with the aim of a descriptive, interpretative and comprehensive narrative elaboration of the phenomena in question, anchored in a theoretical framework and historical time in which they succeed.[27-28]

Method

This work uses as theoretical and methodological basis the studies of Social Psychology, which constitutes an interdisciplinary field, covering knowledge of both social sciences and psychology. Thus, the method that guided the construction of the report was the life story, or life report is a biographical method that is committed to the process of reemoration and reconstruction of the lived by the subject.[4] From the countless situations experienced and the meanings attributed by each one, it allows the researcher to know the intertwinings and tensions between the lived, the acquired and the imaginary. It is a necessarily historical, dynamic and dialectical method, which can narrate through an individual case, a reality shared by a group.[7-8,10]

To access the participants, the research field initially built was the contact with the Foundation for Support to the Apenado (Funap), created by Law 7,533, of September 2, 1986, and whose main purpose is to contribute to the inclusion and reintegration of people arrested, through the training and professional insertion intra and extramuros. Through the articulation with Funap, we obtained access to the Companhia Urbanizadora da Nova Capital do Brasil (Novacap), for which the women included in this research provide services, through an agreement formed between these two instances.

Seven women from the prison system, living in the Federal District and/or RIDE (Integrated Network for Economic Development), aged between 20 and 45 years, among them, were interviewed in the home system and two were in the semi-open. Regarding the marital status of the interviewees, five were single and two married, among them – single and married – four have children. Regarding education, one participant has incomplete high school, three have completed high school, one has incomplete technical education and two have incomplete higher education.

The participants were previously selected for the clinical interview by the immediate manager at work and later according to inclusion criteria, after this first selection, it was verified the availability of time and desire to express their experience. In view of the requirements for selecting key informants. No exclusion criterion was established regarding the time of exit from the prison system or the type of crime committed.

Three instruments were used for data collection: semi-structured clinical interview, family tree and social trajectory.

The semi-structured clinical interview consists of a previously elaborated script, which aims at at the same time to bring out subjective meanings, through the subject's speech, and to be the objective of the research. It is used to know and study the set of values, norms and representations of each individual. It was divided into three moments: 1st moment: Understanding the participant's

history: family, social and historical aspects that marked their life trajectory. 2nd moment: The experience of conflict with the law and incarceration 3rd moment: Expectations and resources for the future extramuros.[29]

The family tree is a graphic representation of the members that make up a family, taking into account the last three or four generations, explaining name, age, profession, geographical location, etc. The instrument relates to the socioaffective origin of the individual and allows us to understand what are the elements present as a family inheritance, the relationship of the individual with the family's life history and how it interferes in the personal destiny of the subject.[3]

The scheme of analysis of social trajectories is visual and intends to illustrate the path and elucidate the transition between the inherited position and the position acquired by the subject in his own history. To this end, the subject's history is constructed from three parallel lines, which put in perspective the characteristics of the various social positions occupied from socio-historical indicators, the main personal and family events and the historical events and social changes that interfered in his course of life.[3]

During the course of data collection, another stage was included in the process, which consisted of the return for each of the interviewees. The return consisted of a previous organization of the data and the construction of a narrative that contemplated the history brought by each participant in the various moments and the reading for the participant. At that time, it was indicated that they could change anything in history or even suppress some information if they did not feel comfortable. In addition, the participant was asked to choose for themselves a pseudonym that would be used at work.

Throughout the fieldwork, the elaboration of a field diary was adopted, where interventions, date and duration, informal conversations and the researcher's impressions were described. The situations experienced of emotional mobilization, such as crying, watery eyes, change in tone of voice, were recorded soon after the interview in the field diary, seeking to recall the details observed. In a way, these scenes could be described only partially, containing my perception as a master, and according to the time and space in which I was located, since many events occurred at the same time.

The field diary contained the experiences, ideas, problems or other perceptions that arose during the fieldwork. The analytical and interpretative records expressed the reflections, generalizations and interpretations of the reading of the previous records.

Data were collected from January to March 2021, totaling three months of field work. All meetings took place in novacap facilities, the women's workplace, in a space assigned to use the research during the interviews and other stages. The meetings took place individually, with approximately 1 hour and 30 minutes of duration each.

In the field of this investigation, listening is related to "what the egressas say about themselves", which already represents an action, because talking and listening is a psychosocial intervention, therefore, allows the egressa to recognize themselves as a subject and contributes to her narre and listen to her own life story from another perspective.

The interviews were transcribed in full and then the texts were revised in relation to spelling, without the essence being modified. General narratives were constructed in order to organize the stories from a temporal logical flow of the facts.

After that, the information was submitted to treatment and analysis, through the content analysis technique, which focuses on speech, as an element that enables the understanding of latent contents. This method of analysis consists of a set of techniques aimed at obtaining, through systematic procedures for describing the content of messages, indicators that allow the inference and interpretation of the messages, respecting the stages of pre-analysis, exploitation of the material, processing of the data and inference of the results.[30]

The categories of analysis were constructed after the organization of the data. The first stage took place through the reading of narratives and the election of relevant topics for analysis, from the theoretical perspective of psychosociology. The second stage was structured from the common themes that were transversal to the stories. The third stage occurred with the elaboration of a table that contemplated the themes, categories and literal statements of each participant, thus evidencing what was actually more frequent and striking. It should be noted that the same category may count similarities or antagonisms of analysis.

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Results and Discussion

Next, the methodological paths adopted since the entry into the field, use of the techniques of participant observation and ethnographic interview, field diary, analysis of information and exit from the field will be discussed.

Entry in the field

The entrance to the field occurred through facilitators who contributed to the accomplishment of this study. Initially, previous contacts were made with people identified as middleman, that is, those who knew the place and could mediate other contacts and information about the study scenario with Funap. This entity aims to make contributions of inclusion and social reintegration of tickets and graduates of the prison system.

At the time of the request for authorization to carry out the study, the director of the institution was contacted, who made a general presentation of the possible locations for the research.

In a second moment, a meeting was held at the institution to present the objectives of the research project, as well as to verify the possibility of starting data collection, in which three meetings were initially expected to be held with each study, including: 1st Clinical interview on life history; 2° Family tree construction; 3rd Analysis of social trajectory. It was explained that it was

intended to hold these meetings individually and in the place where the students performed their work activities.

After this meeting, the development of the research was approved and articulations were made between the institution and one of its contracted companies, in which it was established that the research activities could be developed in two distinct centers of the same organization, which has the character of a public company of the Federal District and has an institutional link with the Secretary of State for Works.

Despite the prior authorization and availability found in the immediate managers of the participants, a rapport was performed at the first meeting to explain the voluntary nature of participation and the objectives of the research. These places employ women in different functions: in the first place, visited, the employees perform administrative functions, in the second, they perform functions related to the profession of living.

With regard to the institution, it was possible to observe that it served subjects on a provisional basis, semi-open regime, closed, conditional, conditional suspension of sentence and imprisonment and house. In view of this, it is perceived that this institution develops actions in the field of work both within prisons and in extramural organizational environments.

Analysis of the researcher's implication

In view of the use of the life history methodology, as well as the objectives of action research, the entire research process described was also composed by the notion of analysis of the researcher's implication, which is characterized by the understanding that the elements that make up the life trajectory of those who propose to investigate are not dissociated from what is investigated, thus, the researcher always leans towards the implication in a movement in which knowledge, life, desires and ethical doing are articulated (Amado, 2005). The implication is a tool in the investigative process that seeks to understand how the scenes lived, heard impact on the researcher himself.[31-32]

Thus, it is possible to verify that it is not feasible for the researcher to be neutral in the field of analysis, because in the meeting possibilities of recognition are produced, with regard to the impacts that the processes experienced in the act of research influence his own life history and vice versa, bringing an overview about the place that it occupies in social relations, for instance.[33]

According to the above, the analysis of implication becomes a fundamental instrument of the process of knowledge construction, being a process capable of making emerge the psychological and social aspects, as well as their relationships, considering that, when in contact with the institution, the researcher is able to work with the path of the senses, the experience that distances itself from objectively investigating the phenomena reaches the meanings.[1]

Therefore, such clinical posture in research presupposes a subjective implication that leads the researcher to the recognition of aspects of his trajectory in the articulation and composition of his intellectual productions.[31]

However, this relationship, which culminates in psychosocial processes, does not result in characterizing the implication as a kind of emotional junction between researcher and researched, it is a methodological work that passes, first, through the way of speech and listening, resulting in an investment of analysis of the lived, difficulties, expectations, absences, privileges, giving vent to the enunciation of emotions, for example, and all this experience is documented through writing.[1]

The elaboration of the implication analysis was carried out after each meeting of field work, this production followed a guide script pre-established by the research group. Which sought to opportunistize a space for reliable and spontaneous textual production, of reflection about what was experienced in the experiences of research.

Participant observation and clinical interview

As the women were presenting availability and desire to share their stories, questions related to the ethical and methodological aspects of the meetings were presented and discussed, being aligned with CNS Resolution 510/16.33 Permission was requested to record the interview and informed about the confidentiality of the information, as well as that no report would be prepared for justice or for Funap itself on the content of the visits worked during the meetings. After providing all the clarifications, the free and informed consent form was signed.

During the interventions, a great expectation was observed that the specific meetings with the psychologist would generate a kind of solution to the problems experienced in daily life. There was a need for a space for dialogue and clarity about the difference between a research that, despite having an interventional dimension, did not have a perspective of systematic clinical follow-up. In view of the observation of this demand, from the need assessment, referrals were made to the formal health network and self-help groups such as anonymous narcotics.

As the interviews took place, more correlations were established between the paradox of intramural life and the experiences of reestablishing an extramural coexistence and life. The participants, in the first days of external work, reported a feeling that life is very raced, of having a lack of time to organize all their personal issues and their family contacts. In the semi-open regime, women had an exact time to leave and enter the prison considering their work routine and the organization of all personal life issues. As if extramural time were perceived and lived differently from the routine imposed institutionally. In the dimension of the institution, time was regulated by the rules imposed and by the group, causing self-management and the variables of an extramural life, such as traffic, the waiting time of public transport to be lived strangely.

Another interesting aspect was, what can be called, the rites of passage of intramural and extramural moments. When they left, they looked for a beauty salon to cut, dress and dye their hair, and they were very concerned with the differentiation of the garments. Within the prison environment, these women can only wear white clothes and slippers and, when they make the transition, even

in the day time to be at work, they make a point of not being seen with the clothes used. In addition to the dimension of appearance the prison also fixated on the body gestures of women, being reported the strangeness when in the extramural environment they do not need to walk with their hands to the back and lower their heads. They reported a sense of freedom in the face of the possibility of moving without rules or an imposition of subjugation.) One cannot reduce the performance of the penitentiary system only the restriction of freedom, but also the application of various punishments in modalities and intensity with varied objectives. It is through the small rituals and the impediment of the exercise of autonomy and spontaneity that prison establishes marks on the psyche of each one who has passed through it. From the repression to the use of certain colors, such as identifying a status to preventing elements that have individual meaning.[34]

This dimension is part of identity, as if there was a social space where she was seen as prey and another where she is seen as a citizen and subject. In the role of prey, due to the crossing of the institution, loses its autonomy and possibility of constructing new everyday meanings. In the exercise of his citizenship, it can be said that it is a citizenship in half, because, despite working and transiting through the city, it is invariably reduced to the position of discharged. The functioning of the total institutions provides for such situations of removal of individual symbols that have a direct relationship with the identity of the subject. Through this dynamic, processes of mortification of the self are established, which take away the individual's ability to represent himself or her. The necessary adaptation that the space requires associated with the compulsory segregation that imposes, causes the establishment of new identities in affective, professional and interpersonal relationships. Women's clothing and vanity elements can be understood as a symbolic element of support for this citizenship fantasy.[25]

Analysis of clinical interviews and field exit

As data were obtained from observations and interviews, time was taken to transcribe and analyze them, elaborating new questions to direct the fieldwork. At the same time, theoretical support was sought in other life history studies and in the learning of the method to direct the performance as a researcher.

At the end of the fieldwork period, much was learned from the seven interviews, both with regard to the experience of graduates and their expectations for the future.

The exit from the field occurred abruptly, with the resumption of a limit situation in relation to the Covid-19 pandemic. From The GDF Decree No. 41,874, of March 8, 2021, activities were suspended and women who were in a semi-open regime had a regression of the sentence, returning to the closed regime and making it impossible to continue data collection. In the days following the Declaration of the World Health Organization (WHO) on March 11, 2020, that the Covid-19 outbreak would become a pandemic, most federative entities began to restrict social and economic activities in order to widen social distance between individuals.

The first Federative Unit (UF) to adopt a mandatory measure was the Federal District, on March 11, when events involving a large number of people were suspended. Since then, the degree of restriction has expanded rapidly in states, municipalities, federal government and foreign governments.

In view of this determination, the research group began to perform the analysis of life histories based on the records obtained from the fieldwork up to that moment. The first step involved reading the sample identifying the semantic relationships and the terms covered and included.

Final Considerations

The daily experiences of collecting life stories were moments rich in learning and research. At the end of this study, the identification of the intersection of social and psychic dimensions in the life trajectory of these women was learned, understanding the breadth that the psychosocial dimension has in daily life and in human behaviors. Throughout the development of the stages of fieldwork, the scenario - including the physical structure, the actors and their relationships with each other - the scenes and events of daily life were unseen and, as the stages occurred, the bond that is constituted between the researcher and the actors was perceived. One of the aspects that had been listed as an important marker of analysis was the question of gender. Despite the few available literature on women and their condition of the inpatients and/or rough, there is unanimity in stating that there is, as an egressa woman, an overweight greater than that experienced by men, however, this dimension was not identified in the participants' statements. The invisibility of patriarchy agencies is present even if there is no awareness on the part of these women.

These data on reality and clinical interviews allowed us to know the symbolic device, institutional characteristics and expectations of care, according to the interpretation of women who experience the prison system. How this moment psychically marked the participants and how this brand remains even after leaving the institution perpetuating itself in the lives of the participants. Degrading and humiliating practices place marks on subjectivity and the search for dignity is as pressing a necessity as the material elements of life.[35] Moreover, the application of punitive logic distorts and prevents the execution of one of the main legal objectives of prison, which concerns resocialization.

The first relevant aspect identified in the participants' speech is what can be called a peninthes within the prison system. In addition to the restrictive penalty of freedom, there is the use of other elements such as the restriction and commitment of the quality of food, clothing and other elements that can serve to subjugate the subject in the execution of the penalty.

The use of a life history method favored the direction of action in the field, in view of the objective that was sought to achieve. The process of hearing the reports and weaving the stories was of fundamental importance for the construction of the narrative, presented at the moment of return to each of the interviewees. This was the moment when the method was made practical.

We constantly learn in the social life of our daily lives, perhaps not explicitly, as in the role of researcher. In the process of approximation with the interviewees, the performance of the implication analyses and, consequently, the elucidation of the reviews that each of us has in listening was also a relevant point. This is because our beliefs and values are built on a solid basis and often unconsciously, throughout life.

The development of the ability of the psychosocial look among health professionals, especially psychology professionals, due to the proximity they develop with the human beings they care for, can improve health practices.

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Records of police "stalking" occurrences in Brasília (DF) and administrative regions, 2021

Registros de ocorrências policiais de "stalking" em Brasília (DF) e regiões administrativas, 2021

Registros de casos policial de "stalking" en Brasília (DF) y regiones administrativas, 2021

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RESUMO

Objetivo: Desenvolver uma reflexão no que se refere ao crime do "Stalking", registrado por meio de ocorrências policiais na cidade de Brasília, Distrito Federal (DF) e regiões administrativas no ano de 2021. **Método:** Os dados foram adquiridos junto a Divisão de Análise Técnica e Estatística (DATE), pertencente ao Departamento de Inteligência e Gestão da Informação (DIGI) da Polícia Civil do Distrito Federal (PCDF). Foi implementada análise estatística do tipo descritiva e os resultados foram expostos utilizando uma figura e uma tabela. **Resultados:** Foi identificado o universo de 1.673 casos, com média e desvio-padrão (167,3±61,0). Os meses de agosto e setembro registraram as maiores preponderâncias, cada um com 12,6% (n=210) e março a menor com 0,4% (n=06). **Conclusão:** Por meio da presente pesquisa foi possível verificar a importância da Lei Federal de número 14.132/2021, objetivando tipificar o fenômeno do "Stalking". Também foi possível perceber que o referido dispositivo legislativo, incentivou o registro de ocorrências policiais, além de contribuir para o combate, mitigação e controle deste crime.
Descritores: Stalking, Violência, Violência contra a Mulher.

ABSTRACT

Objective: To develop a reflection regarding the crime of "Stalking", recorded through police occurrences in the city of Brasília, Federal District (DF) and administrative regions in the year 2021. **Method:** Data were acquired from the Division of Technical and Statistical Analysis (DATE), belonging to the Department of Intelligence and Information Management (DIGI) of the Civil Police of the Federal District (PCDF). Descriptive statistical analysis was implemented and the results were exposed using a figure and a table. **Results:** The universe of 1,673 cases was identified, with mean and standard deviation (167.3±61.0). The months of August and September registered the highest preponderances, each with 12.6% (n=210) and March the lowest with 0.4% (n=06). **Conclusion:** Through the present research, it was possible to verify the importance of the Federal Law number 14.132/2021, aiming to typify the phenomenon of "Stalking". It was also possible to perceive that the aforementioned legislative device encouraged the registration of police occurrences, in addition to contributing to the fight, mitigation and control of this crime.
Descriptors: Stalking, Violence, Violence against Women.

RESUMEN

Objetivo: Desarrollar una reflexión sobre el delito de "Acoso", registrado a través de incidentes policiales en la ciudad de Brasilia, Distrito Federal (DF) y regiones administrativas en el año 2021. **Método:** Los datos fueron adquiridos de la División de Técnico y Análisis Estadístico (DATE), perteneciente a la Dirección de Inteligencia y Manejo de la Información (DIGI) de la Policía Civil del Distrito Federal (PCDF). Se aplicó el análisis estadístico descriptivo y se expusieron los resultados mediante una figura y una tabla. **Resultados:** Se identificó el universo de 1.673 casos, con media y desviación estándar (167,3±61,0). Los meses de agosto y septiembre registraron las mayores preponderancias, cada uno con 12,6% (n=210) y marzo la menor con 0,4% (n=06). **Conclusión:** A través de la presente investigación, fue posible verificar la importancia de la Ley Federal número 14.132/2021, con el objetivo de tipificar el fenómeno del "Stalking". También se pudo percibir que el mencionado dispositivo legislativo incentivó el registro de las ocurrencias policiales, además de contribuir al combate, mitigación y control de este delito.
Descriptores: Acoso, Violencia, Violencia contra la Mujer.

ORIGINAL

Introduction

The term "stalking", originated from the English language and used in the practice of "hunting", has as a translation into Portuguese, according to some authors, the act of "insistent pursuit", or "incessant pursuit" and, by extension, the violence developed by one or several people, in relation to a victim, in the invasion(s) of privacy, intimacy, intimate life or even in private life.[1,2] For some researchers, the crime of stalking represents a form of misdemeanor, or even a complex pattern of behaviors, related to the phenomenon of harassment, characterized by persistence and which involves various mechanisms of contact, communication, monitoring and surveillance, directed at a "target person" , on the part of another, that is, the "stalker", the persecutor.[2,7,11]

Due to the advent of technology as one of the main characteristics of industrialized and post-industrialized societies in contemporary times, stalking can also be identified, through the development of publication(s) of fact(s) together with social and communicational media on the internet, usually with the sending of messages by the "Short Message Service" (SMS), that is, by the "short message service", by electronic mail, by making telephone calls, among many other ways.[1,2,11] Stalking comes being researched and analyzed, as a social problem in several nations, being verified as a modus operandi of the persecutor, the use of various strategies and complex tactics related to this crime, using various technological means to implement this form of violence, classified by some researchers as "cyberstalking", "cyberstalking" or even "cyberharassment".[2,4,7,11,12]

According to some experts on the subject, in 1980, as a result of the murder of British peace activist, singer and songwriter John Lennon, the practice of stalking began to receive greater attention in the media and communication media.3 Another fact related to the stalking phenomenon , which took place in 1981, was the assassination attempt on the American head of state Ronald Reagan by John Hinckley Jr, who declared that he had committed this crime, aiming to draw the attention of Jodie Foster, an American actress and internationally known, by whom he was, in his own words, "obsessed."[3]

As identified in the scientific literature, the first research and systematic studies implemented in this complex crime were developed mainly in Anglo-Saxon nations, such as Germany, Australia, the United States of America (USA), England and Wales, being methodologically organized, in relation to the prevalences and quantities identified.[2,7] In a study carried out in England, it was proposed that the main people who are in conditions of vulnerability in relation to the crime of stalking, females and young people, and those with a lower age group are the most affected, due to a greater use and exposure to communication and informational media for recreational purposes, presenting a greater risk factor and also,

expanding the possibility of being victimized by this crime, when compared to older people.[4,7,12]

In Brazil, Law number 14,132 of March 31, 2021 was enacted, which added article 147-A to the Brazilian Penal Code (CP), that is, Decree-Law number 2,848, of December 7, 1940, having as a goal, to predict the crime of stalking and, aiming to develop the combat and control of the stalking crime in all its modalities.[5,6,7] In this sense, the "Brazilian Law against Stalking", as it is more popularly known, defines this crime as the act of "persecuting someone, repeatedly and by any means, threatening their physical or psychological integrity and restricting their ability to move around or, in any way, invading or disturbing their sphere of freedom or privacy".[5,7]

In this way, and according to this important national legislation, for people who commit this crime of persecution, the stipulated penalty can generate imprisonment ranging from six (06) months to two (02) years, in addition to a fine and, in cases where the victim is a child, an adolescent or an elderly person, the penalty is increased.[5,7] The penalty for the crime of stalking is also increased, in cases where the victim is constituted as a woman, for reasons of female status, under the terms of § 2-A of article 121 of the CP, by means of a contest of two (02) or more people, or with the use of a weapon.[5,7]

As identified in the 2022 Brazilian Public Security Yearbook, produced by the Brazilian Public Security Forum (FBSP), a universe of 27,772 stalking cases were identified throughout Brazil in 2021, according to a survey implemented in twenty-two (22) units Federations (UFs), being recorded every hour, approximately three (03) cases.[8] In this context of typification of the crime of stalking and, as a result of the sanction of Law 14.132/2021, as a way of combating violence directed at women, this constitutes an important indicator, related to the risk of death emanating from the victim.[5,6,8,10,11]

In this sense, it was constituted as an objective of the present research, to develop a very brief reflection regarding the crime of "Stalking", registered through police occurrences in the city of Brasília, Federal District (DF) and administrative regions, in the year 2021.

Method

This was an exploratory and descriptive research, using data classified as secondary, acquired from the Division of Technical Analysis and Statistics (DATE), belonging to the Department of Intelligence and Information Management (DIGI) of the Civil Police of the Federal District (PCDF) . Aiming to substantiate and contextualize the acquired data, articles from scientific journals, official reports and related legislation were also used, acquired after an electronic bibliographic survey with computerized databases.

The databases used were Google Scholar (Google Scholar), the Virtual Health Library (VHL), Bibliographic Database on Health Care in Iberoamérica (Cuiden), Saber-USP, Minerva-UFRJ and Theses-FIOCRUZ. The Descriptors in Health Sciences (DeCS)/MeSH of the VHL were used, and they are shown next to Table 1.

Table 1 – Presentation of the DeCS/BVS used in the acquisition of the references used:

Descriptor	Identifier DeCS	Writer ID
Sexual harassment	30511	D017406
Sexual offenses	13122	D012742
Exposure to violence	56165	D000069581
Persecution	53260	D055807
Violence	15158	D014754
Violence against women	50239	DDCS050239
Gender violence	56876	D000074386
Domestic violence	31499	D017579
Ethnic violence	55429	D064868
Violence at work	55427	D064450
Intimate partner violence	56155	D000066511

Source: violence against women, 2022.

As inclusion criteria, references in the language in "Portuguese" and "English" were used. As exclusion criteria, references that were in the format of "summary of scientific congresses and events" and "references that were found in duplicate" were removed.

Descriptive statistical analysis was implemented, with percentage calculations (%), mean (Me) and standard deviation (SD).

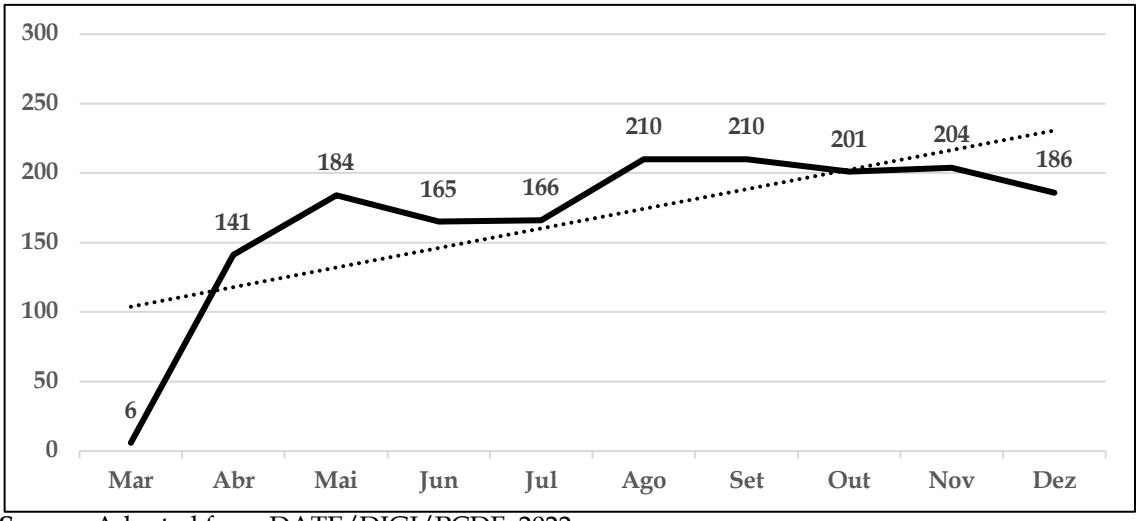
The generated results were exposed using one (01) figure and one (01) table. The authors of this research declare that there are no conflicts of interest.

Results and Discussion

According to data acquired from the Civil Police of the Federal District (PCDF), in the city of Brasília (DF) and in its administrative regions in 2021, a

universe of 1,673 stalking reports registered through police occurrences was identified, with an average of 167.3 and standard deviation (SD) of 61, and these data are shown together with Figure 1.[9]

Figure 1 – Presentation of stalking reports in the city of Brasília (DF) and administrative regions, 2021 (n=1.673):*,**



Source: Adapted from DATE/DIGI/PCDF, 2022.
* The authors are faithful to the source consulted.
** Due to several factors, the exposed data may undergo alteration(s) in its composition.

In this sense, it is possible to verify the increase in the frequency of stalking cases records, after the enactment of the Federal Law presented, being verified the efforts developed in the fight, control and mitigation of this crime and also, its direct and indirect impacts on society. [9] It was also possible to verify in the geographic and historical scope in question, that the months of August and September registered the highest preponderances each with 12.6% (n=210) and March the lowest with 0.4% (n=06), as shown in Table 2.[9]

Among the main problems emanating from the stalkink crime, as a result of the persecution developed incessantly and continuously against the victim, the emergence of psychological disorders, emotional suffering and, therefore, the correlation of this crime with emotional and psychological violence.[8, 12] In an important systematic review developed in Portugal, complications related to their "psychological health", in their "physical health" and also consequences in their "lifestyle and economy" were identified as impacts identified in university students victimized by the crime of stalking. of the victim".[12]

Table 2 - Presentation of stalking reporting records in the city of Brasília (DF) and administrative regions, by months, frequency, percentage, mean and standard deviation, 2021 (n=1.673):*,**

Months	f	%	Average	DP
March	6	0,4	-	-
April	141	8,4	-	-
May	184	11,0	-	-
June	165	9,9	-	-
July	166	9,9	-	-

August	210	12,6	-	-
September	210	12,6	-	-
October	201	12,0	-	-
November	204	12,2	-	-
December	186	11,1	-	-
Total	**1.673**	**100**	**167,3**	**61**

Source: DATE/DIGI/PCDF, 2022.
* The authors are faithful to the source consulted.
** Due to several factors, the exposed data may undergo alteration(s) in its composition.

Regarding psychological health, the emergence of anxiety, depressed mood, fear, anger was pointed out and, in relation to physical health, the presence of headache, muscle weakness and sleep disturbances was identified. Regarding the consequences generated by stalking attacks, in relation to the victim's lifestyle and economy, social isolation, the loss of friends and also the change of identity were identified with the research participants.[12]

When analyzing the impact of cyberstalking on university students, occurrences were identified, in the "economic", "social" and "psychological health" areas of the victim, and in the first one, the existence of modification of the cell phone or residential device number was verified. and also, investment(s) in program(s) and software(s) for greater technological protection to the respective attacks.[12] As for the social area, changes were identified as modifications, social isolation, changes with regard to the professional and/or academic performance, lack with the employing institution or also, in the classes developed with the higher education institution (HEI) developed weekly, in addition to dismissal/dismissal from the job, and also, suspension and/or withdrawal from the university course that was attending.[12]

Regarding the psychological health of university student's victims of cyberstalking, the presence of anxiety, fear, anger and feeling their security threatened was verified and, in terms of physical health, fatigue, headaches and sleep disturbances were verified.[12] In this way, the need to encourage other processes and mechanisms for reporting stalking and cyberstalking cases is easily perceived, as a way of combating this crime of curtailing the right to personal freedom.

Final Considerations

There is a need to implement other policies, public policies and intelligent strategies, aimed at combating, controlling and mitigating the crime of stalking and cyberstalking. harassment. In this way, society, social movements, professional associations and political institutions must redouble their efforts and articulations, in order to encourage the realization of new studies and research, which approach and analyze in depth the crimes of stalking and

cyberstalking. , aiming to allow, in addition to a greater knowledge of this criminal phenomenon, the emergence of other efficient and effective protective measures for the care, treatment and defense of countless victims.

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Contributions by Dr. Aurora de Afonso Costa for nursing care for burn victims

Contribuições da Dra. Aurora de Afonso Costa para o cuidado do enfermeiro a pacientes vitimados de queimaduras

Aportes del Dr. Aurora de Afonso Costa por cuidados de enfermería a quemados

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RESUMO

Objetivo: Analisar as contribuições da Dra. Aurora de Afonso Costa, para o cuidado do enfermeiro a pacientes vitimados de queimaduras. **Método:** Trata-se de um estudo classificado enquanto documental e de abordagem qualitativa. As fontes primárias se constituíram de artigos de periódicos científicos, produções acadêmicas, livros, sites e portais eletrônicos, leis, decretos, decretos-leis, dentre outros. **Resultados:** Foi identificado num artigo idealizado pela eminente docente e pesquisadora, questões relacionadas a anatomia, a fisiologia, os graus de complexidade, os tipos, o processo cicatrizacional, a extensão, a área de prioridade, o tratamento medicamentoso e a utilização de "ambrina". **Conclusão:** A presente pesquisa apontou as contribuições da Dra. Aurora no tratamento de pessoas vitimadas de queimaduras, os primeiros cuidados a serem implementados com a pessoa vitimada, e a implementação de curativos e coberturas para o seu reestabelecimento e reabilitação.

Descritores: Enfermagem; Queimaduras; Primeiros socorros.

ABSTRACT

Objective: To analyze the contributions of Dr. Aurora de Afonso Costa, for nursing care for burn victims. Methods: This is a study classified as documentary and with a qualitative approach. The primary sources consisted of articles from scientific journals, academic productions, books, websites and electronic portals, laws, decrees, decree-laws, among others. Results: In an article conceived by the eminent professor and researcher, issues related to anatomy, physiology, degrees of complexity, types, the healing process, extension, priority area, drug treatment and the use of "ambrina ". Conclusion: The present research pointed out the contributions of Dr. Aurora in the treatment of burn victims, the first care to be implemented with the victim, and the implementation of dressings and coverings for their reestablishment and rehabilitation.

Descriptors: Nursing; Burns; First Aid.

RESUMEN

Objetivo: Analizar las contribuciones del Dr. Aurora de Afonso Costa, por la atención de enfermería a los quemados. Métodos: Se trata de un estudio catalogado como documental y con abordaje cualitativo. Las fuentes primarias consistieron en artículos de revistas científicas, producciones académicas, libros, sitios web y portales electrónicos, leyes, decretos, decretos-leyes, entre otros. Resultados: En un artículo concebido por el eminente profesor e investigador, se abordaron temas relacionados con anatomía, fisiología, grados de complejidad, tipos, proceso de cicatrización, extensión, área prioritaria, tratamiento farmacológico y uso de "ambrina". Conclusión: La presente investigación señaló los aportes del Dr. Aurora en el tratamiento de las víctimas de quemaduras, los primeros cuidados que se implementarán con la víctima y la implementación de vendajes y coberturas para su restablecimiento y rehabilitación.

Descriptores: Enfermería; Quemados; Primeros Auxilios.

ORIGINAL

Introduction

Among the countless, illustrious and dedicated professors, representatives of the Aurora de Afonso Costa Nursing School, of the Fluminense Federal University Medical Sciences Center (EEAAC/CCM/UFF), Dr. Nurse Rosalda Cruz Nogueira Paim, Dr. Nurse Maria Wanda Rodrigues de Oliveira, and also, her "eternal guide", Dr. Nurse Aurora de Afonso Costa.[1,2,3] Aurora Gypsophila de Afonso Costa, better known as Aurora de Afonso Costa, or simply Dona Aurora, was born on December 4, 1903, in the city of Morro do Chapéu, in the state of Bahia (BA), being the daughter of Mr. Affonso Costa and Mrs. Presciliana da Silva Costa.[1,3,4]

In her youth, she had the opportunity to take a teaching course at Escola Normal and, when she lived in her hometown, before dedicating herself to the professional category of nursing.[1,4,5,6] Aiming to complete her graduation, as well how to ascend socially and professionally, she had the opportunity to travel to the state of Rio de Janeiro (RJ), at the time, the Brazilian federal capital, managing to enter in 1923 and, later, completing her course, being graduated on the 14th August 1927, at the Ana Néri School of Nurses of the former University of Brazil (UB). [1,4,5,6,7]

Currently, the former Ana Néri School of Nurses at the UB is called Anna Nery School of Nursing of the Health Sciences Center of the Federal University of Rio de Janeiro (EEAA/CCS/UFRJ).[8] This eminent institution of higher education (IES), was constituted as the first College of Nursing of higher level in Brazil, appearing historically in the context of the Brazilian sanitary movement, initiated as proposed by the scientific literature in the 20th century and, being created by Decree number 16.300, dated 31 December of the year 1923.[8,9]

In view of the legislative issue, it was possible to verify that Decree number 16,300, of 12/31/1923, was revoked by the Decree **of September 5, 1991**, which reserved the legal effects of declarations of social interest or public utility and also revoked the the decrees that it mentions.[9,10] This important institution called School of Nurses of the National Department of Health, received the name of School of Nurses D. Ana Néri, effected by Decree number 17,268 on 03/31/1926, thus being , it was possible to implement the Nursing career in the "Nightingaleano" model at the national level and, later, it was incorporated into the UB, through Law number 452, dated on 07/05/1937.[9,10,11]

In this important governmental institution, Dr. Aurora had the opportunity, due to her dedication, effort, commitment and sagacity, to gradually ascend from a student to a teaching career, thus contributing to the training of countless nurses.[1,3,4,5,6,7] Among the various activities developed by Dr. Aurora, still with the EEAN of the UB, was identified her participation and active militancy, developing the role of vice-president of the Commission, in the creation of the magazine "Pioneira".[12]

Among one of her greatest attributions, she managed to get selected to occupy the position of director of the institution that would be founded next to the city of Nitéroi in RJ, the then School of Nursing of the State of Rio de Janeiro (EEERJ), taking office in the day 10/09/1944 and, remaining in that position for its competence and representation for approximately twenty-two (22) years.[1,3,4,5,6,7,12,15] One of the facts that point to the force, the determination and the determination of her management, it can be mentioned the fact that Dr. Aurora conquered, for the EEERJ, the number of fourteen (14) "Chairs", which were filled only by nurse-professors, a historical process that was characterized by some researchers as a true "political war".[1,3,4,15,16]

It is also important to highlight, with regard to the historical phenomenon of the acquisition of the EEERJ Chairs, and the aforementioned "political war", that these issues allowed the emergence of battles in judicial spheres, with some medical professionals.[1,3,4,15,16] Among the important activities developed, Prof. Aurora also had the opportunity to serve politically for the benefit of the professional category of nursing and health, together with the former Brazilian Association of Graduate Nurses (ABED), currently the Brazilian Nursing Association (ABEN).[1,4,5,6, 7,13,14]

In this important body of the professional category of Brazilian nursing, in its section of the state of Rio de Janeiro (ABEN-RJ), Dr. Aurora is characterized as a "founding partner", in addition to having had the opportunity to develop activities, as an integral member of its "Fiscal Council" started in 1950 and, of the "Deliberative Council", already in 1951.[13,14] Among the several honors received by Dr. Aurora, it can be mentioned the designation of the commendation, Order of Merit Araribóia, in its Official degree, granted by the Mayor of the City of Niterói (RJ), through Decree number 4.368/1984.17

In this sense, the governmental recognition of its importance in the development of the process of foundation, growth and development of the former EEERJ is easily perceived, through its direction carried out for more than two decades, uninterrupted.[17] Unfortunately, as a result of the process of aging and illnesses contracted in her existence, Dr. Aurora died at the age of 95, on January 27, 1999, at the Antônio Pedro University Hospital (HUAP) of the Fluminense Federal University (UFF), headquartered in Niterói (RJ), leaving an irreparable gap in the nursing and in the field of healthcare.[1,3,4,5,6]

His last request left was that his body be cremated in addition to having his ashes deposited next to the Guanabara Bay in RJ, located near the headquarters of the Nursing School that worked so hard during its foundation, growth and development and that, at present, , has his name.[4,5,6,12,15] Thus, we fully agree with the words of Prof. Cléa Alves de Figueiredo Fernandes, in her book that analyzes the founding process of EEERJ, when referring to Dr. Aurora, declaring that *"... Aurora ... is in this case a symbolic name", "symbol of a dream, of new forces, of the incessant search for the ideal, And this "aurora" at every moment knew how to bring the trust that was so much needed to overcome the long and painful days unfolded in the course of these two decades..."*.[1]

In this sense, the objective of this research was to analyze the contributions of Dr. Aurora de Afonso Costa, for nursing care for burn victims.

Method

This is a documentary study with a qualitative approach, and the primary sources of this research were articles from scientific journals, academic productions, books, websites and electronic portals, laws, decrees, decree-laws, among others. In order to facilitate the process of acquiring references for the construction of the present study, electronic bibliographic surveys were carried out with computerized databases such as the Gragoatá Central Library (BCG) at the Fluminense Memory Center (CMF) of the UFF, the Jane Proença Library of UFF School of Nursing (BENF), the Virtual Health Library (BVS), Google Scholar (Google Scholar), Minerva-UFRJ, the Institutional Repository of the Fluminense Federal University (RIUFF), Saber-USP and TESES- FIOCRUZ.

Also aiming to expand the process of acquiring the necessary subsidies for the preparation of this research, the Descriptors in Health Sciences (DeCS)/MeSH of the VHL will be used, being the same, "Nurses" with the DeCS identifier "9913" and the ID descriptor "D009727", "Wounds and injuries" with DeCS identifier "15345" and descriptor ID "D014947", "Burns" with DeCS identifier "2088" and descriptor ID "D002056", "Eye burns" with DeCS identifier "28014" and descriptor ID "D005126", "Electric current burns" with DeCS identifier "2090" and descriptor ID "D002058", "Inhalation burns" with DeCS identifier "2091" and descriptor ID "D002059", "Chemical burns" with DeCS identifier "2089" and descriptor ID "D002057".

To facilitate the use of the VHL DeCS, the Boolean logical operators were used in the search **"and", "or" and "not", according to the methodology proposed by EBSCO Connect©, present at the electronic address [https://connect.ebsco.com/s/article/Search-with-Booleanperators?Language=en_US]**. After acquiring the necessary subsidies for the construction of the present study, they were read and analyzed for later, two (02) investigative tables were set up, aiming to allow a better understanding and understanding of them. After this step, the synthesis of the acquired results was carried out, thus facilitating the writing of the final article.

Results and Discussion

Before starting the process of analyzing the article created by Dr. Aurora, it is of fundamental importance to carry out a brief temporal reflection, regarding the time of publication of this instigating scientific paper. In this way, a very brief historical retrospective of the main facts and events that have strongly influenced Dr. Aurora to build the scientific article in question.

In the international field, it can be remembered that in 1934, the government of Adolf Hitler began in Germany, during the period between 1939 and 1945, when a war of global proportions was developed and that would be known as World War II (WWII).19 In Brazil, the Constitution of 1934 is promulgated by the National Constituent Assembly, being drafted with the aim of *"[...] organizing a democratic regime that assures the nation, unity, freedom, justice and social and economic well-being*."[19,20]

With regard to the professional nursing category, it is important to remember Decree number 23,774, of January 22, 1934, which extended to

practical nurses the benefits granted to pharmacists and practical dentists, regarding the exercise of their respective functions. 21 This important Decree, which caused some changes in the nursing category, was revoked by Law number 2,604, of September 17, 1955, which regulated the practice of professional nursing, and this decree was later revoked by Law number 7,498/ 1986, but known as the Law of Professional Nursing Practice (LEPE), prevailing to date.[21,22,23]

These important facts have possibly contributed to the expansion of interest related to the various constitutive fields of health, for example, first aid and its application in urgent and emergency situations, such as burns, in their various types and forms. constitutions.[19,20,21,22,23] According to some researchers, in the year 2004, approximately 11 million recorded burns occurred all over the world, which received an indication for specialized medical treatment, and of these, about 300,000 resulted in the death of the patient victimized by this type of phenomenon.[25]

As found in some studies and specialized research, the phenomenon of burns is classified as the fourth (4th) leading cause of injuries recorded in all countries, behind only car accidents along highways, falls and falls from heights, and also, the various types and modalities of violence.[25] Therefore, the importance and the need to develop systematic studies and research, aiming to better understand this complex phenomenon and its various consequences, in the search for better forms of treatment and specialized therapies for this patient.[24,25]

In this context, it can be argued that the scientific article in question constitutes an important publication identified in the journal "*Annaes de Enfermagem*", the first Brazilian scientific journal of this category and which would become the "Brazilian Journal of Nursing - REBEN ", lecturing on important techniques and procedures, used for the care of patients who are victims of various issues related to burns and their forms of treatment".[24] In his own words, and introducing the article developed in relation to knowledge related to first aid. for people who were victims of burns that they were indispensable, with regard to *"[...] to everyone's knowledge, since it is very common to have small accidents in which we are forced to act"*.[24]

In this way, and for Dr. Aurora, among the most common accidents, could be highlighted the *"[...] burns, asphyxia by gas or water, heat stroke, syncope, fracture, hemorrhages, poisoning, etc."*[24] What is interesting in its scientific production, is the richness identified in the various concepts and techniques presented, as well as in the anatomophysiological and even visual constitution, with which the problem is dissected by Dr. Aurora, thus facilitating the process of knowledge construction by readers, students and nursing and health professionals, being even divided by its different types or degrees of complexity, as shown in table number 01.

Table 1 – Presentation of the different types of burns by their respective degrees:*

Grau	Description
Grade 1	It is characterized by rubefaction, red skin, superficial inflammation.
Grade 2	Cutaneous inflammation, with detachment of the epidermis and formation of vesicles filled with serosity, which are called fictenes.
Grade 3	Tissue necrosis, which may reach only the skin or even go deep into the bone.

Source: Adapted by the authors, 2022.

* The authors of this research are faithful to the information consulted.

Aware of the complexity and magnitude of some cases related to burns and other issues of first aid or urgency and/or emergency, for example, it is reflected on the healing process, in addition to the normalization and restoration of general functions, where, it is sustained by Dr. Aurora, in her publication that, *"[...] in some cases, the fact of extension should be much more present than its priority"*.[24] Another important contribution by Dr. Aurora pointed out in her article, were the different types of drug treatments for patients suffering from burns, as presented next to table number 02.

Table 2 – Presentation of the types of drug treatments for burn victims by different degrees:*

Grau	Description
Grade 1	Cover the burn area with petroleum jelly or a bicarbonate of soda paste with alcohol next to the surface. Aiming to relieve pain.
Grade 2	Complete cleaning with soap and water or saline solution around the burned area. The blisters that are already open are removed, those that are still closed are punctured, then the dressing is made with sterilized Vaseline.
Grade 3	The same aseptic precautions currently recommended are used; one waits for the bedsores to disaggregate, even helping to eliminate them with tweezers or scissors.

Source: Adapted by the authors, 2022.
* The authors of this research are faithful to the information consulted.

Another important point identified in the article under analysis is the therapeutic use of "ambrina" in the treatment of burns, which, in his words, is "[...] the best treatment, because [...] results obtained as a result of its application".24 As defended by Dr. Aurora, in the treatment of patients who had burns, ambrin consisted of its composition, "[...] by a mixture of wax, resin and paraffin".24

The importance provided by Dr. Aurora is such in relation to treatment with ambrina in burn victims that its modus operandi of care is gradually explained by this research, in the treatment and therapies proposed for the reestablishment of the health service user, in all its stages. constitutive measures, in addition to the procedures and techniques used.[24]

As defended by Dr. Aurora, this care technique developed by the nurse or nursing professional, should "[...] *dissolve it in a "bain marie" and, after this process, wash the burned area carefully with soap and water; after drying, the first layer of ambrin is placed directly on the site, using an appropriate sprayer, or a brush or even a gauze doll*."[24] Continuing the interesting technique of treatment and therapy against burns, is defended by Dr. Aurora that, "*over this first layer of ambrin, a gauze is placed and on top of this, another layer of ambrin and thus, the dressing is done*".[24] According to their conceptions, as well as, in relation to the technique defended by Dr. Aurora, "*this dressing must be 24 or 48 hours later, as the case may require.*"[24] Regarding the process of protection and coverage of the dressing and treatment of burns proposed by Dr. Aurora, was defended by her, as an important covering technique, that "*the fixation of the same should be performed using bandages*".[24]

Another important suggestion proposed by Dr. Aurora in the treatment and recovery of patients suffering from burns in the areas of the hands, is "[...]

the need to place a piece of gauze on the roots of the fingers, between each phalanx, to prevent scarring with adhesions". [24] Therefore, Dr. Aurora strongly supported in her article, "[...] *the need to use bandages of the "Demigauntlet"* or "*Gauntlet*" type, aiming at greater fixation and protection coverage, in the area where the protective dressing was implemented.[24]

Ambrina was constituted in the field of botany and, according to some researchers, a certain type of plant of the "*herbaceous*" type, belonging to the family of "*chenopodiaceae*" and which had its leaves characterized, more or less, in the triangular shape.[26] In the areas of pharmacy, chemistry and biochemistry, it was constituted as a form of mixture implemented with the addition of paraffin and other essences and whose objective was the treatment of burns.[26]

In another publication, the use of ambrin was identified in the treatment of patients diagnosed with corneal ulcer, as its use allowed its "[...] *easy application and removal, [in addition to being] harmless, [and also] an excellent insulator, without harming most of the recommended treatments*."[26] On the other hand, another innovation in the care implemented by the professional nurse in the care of this patient is also presented, described by Dr. Aurora in her scientific journal article, in the implementation of knowledge from related areas of health and biohealth, such as pharmacy, biochemistry and botany, aiming to enhance the healing process of the burn, in addition to accelerating the recovery and rehabilitation of the user(s) of the health service(s) undergoing treatment.[24]

Final Consideration

Through this article, it was possible to identify the contributions made by Dr. Aurora in the care developed by nurses, nursing and health professionals, to patients suffering from burns. The identification of an article published by Dr. Aurora, together with the important journal Annaes de Enfermagem, points to the importance provided by this eminent professor and researcher, in matters related to burns, dressings, first aid and emergency and emergency care.

In this sense, it is possible to defend the identification exposed in the present research, of an unknown area of research worked by this distinguished representative of the professional category of nursing. In this context, the realization of other academic productions, which deal with the provision of nursing care with burn victims, their specialized treatments and rehabilitation therapies, should be strongly encouraged and supported, aiming to provide better subsidies for their care. resettlement.

The present research also pointed to the performance of Dr. Aurora, along with productions in the area of first aid, allowing us to suppose that other researches have been implemented, in the course of their militancy and work with the tripod of education, that is, in teaching, research and extension. Another fact identified in relation to Dr. Aurora, was the introduction of ambrina, as a form of better treatment for people suffering from burns in its various modalities, pointing to the innovative character and perspective, in the search for new forms of care for victims and, in this way, fully contributing to the expansion of new lines of care, in the quality of treatment of these patients.

The use of illustrative drawings for a better understanding of the techniques and knowledge proposed in the article published by Dr. Aurora, also point to her versatile posture and also, a differential presented by her to the

analyzed article. The proposition of using certain types of bandages, implemented as the best and most efficient dressing and covering technique, in the care implemented in burn victims, were also identified in the manuscript in question, pointing to a better choice of supplies to be used. in carrying out the techniques and procedures described.

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