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Nursing and the promotion of humanized care for hospitalized children with malnutrition: a qualitative study

Enfermería y promoción de la atención humanizada a niños hospitalizados con desnutrición: un estudio cualitativo

A enfermagem e a promoção da humanização do cuidado à criança hospitalizada com desnutrição: estudo qualitativo

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Abstract

The aim was to analyze the nursing team's performance in promoting the humanization of care for hospitalized children with malnutrition. A descriptive and exploratory study with a qualitative approach, conducted in a pediatric ward of a university hospital in the state of Rio de Janeiro. Ten nursing professionals participated, including nurses, nursing residents, and nursing technicians. Data were collected through semi-structured interviews, recorded in full, and subjected to Content Analysis, according to Bardin. The study was approved by the Research Ethics Committee under opinion No. 7,462,608. Four categories were identified: humanization practices in daily care; humanization as a strategy for stress reduction and bond strengthening; perceived repercussions of humanization on care acceptance and clinical evolution; and active and individualized listening as a therapeutic tool. Participants highlighted the use of play strategies, empathic communication, respect for the child's time, caregiver involvement, and individualization of care. In the professionals' perception, humanization qualifies the care of hospitalized children with malnutrition, favoring welcoming, safety, care acceptance, and the strengthening of bonds between the child, family, and nursing team.

Descriptors: Humanization of Care; Pediatric Nursing; Child Malnutrition; Hospitalized Child; Nursing Care.

Resumén

El objetivo fue analizar el desempeño del equipo de enfermería en la promoción de la humanización de la atención a niños hospitalizados con desnutrición. Se realizó un estudio descriptivo y exploratorio con enfoque cualitativo en una unidad de pediatría de un hospital universitario en el estado de Río de Janeiro. Participaron diez profesionales de enfermería, incluyendo enfermeros, residentes de enfermería y técnicos de enfermería. Los datos se obtuvieron mediante entrevistas semiestructuradas, grabadas y transcritas en su totalidad, y se sometieron a un análisis de contenido según la metodología de Bardin. El estudio fue aprobado por el Comité de Ética en Investigación (dictamen n.º 7.462.608). Se identificaron cuatro categorías: prácticas de humanización en la atención diaria; la humanización como estrategia para reducir el estrés y fortalecer los vínculos; repercusiones percibidas de la humanización en la aceptación de los cuidados y la evolución clínica; y la escucha activa e individualizada como herramienta terapéutica. Los participantes destacaron el uso de estrategias lúdicas, la comunicación empática, el respeto por los tiempos del niño, la participación de los cuidadores y la individualización de la atención. Según la percepción de los profesionales, la humanización cualifica la atención a los niños hospitalizados con desnutrición, favoreciendo la acogida, la seguridad, la aceptación de los cuidados y el fortalecimiento de los vínculos entre el niño, la familia y el equipo de enfermería.

Descriptores: Humanización de la Atención; Enfermería Pediátrica; Desnutrición Infantil; Niño Hospitalizado; Cuidados de Enfermería.

Resumo

Objetivou-se analisar a atuação da equipe de enfermagem na promoção da humanização do cuidado à criança hospitalizada com desnutrição. Estudo descritivo e exploratório, de abordagem qualitativa, realizado em uma enfermaria pediátrica de um hospital universitário do estado do Rio de Janeiro. Participaram dez profissionais de enfermagem, entre enfermeiras, residentes de enfermagem e técnicas de enfermagem. Os dados foram produzidos por meio de entrevistas semiestruturadas, gravadas, transcritas na íntegra e submetidas à Análise de Conteúdo, conforme Bardin. O estudo foi aprovado pelo Comitê de Ética em Pesquisa sob o parecer n.º 7.462.608. Foram identificadas quatro categorias: práticas de humanização no cotidiano da assistência; humanização como estratégia para redução do estresse e fortalecimento do vínculo; repercussões percebidas da humanização na aceitação do cuidado e na evolução clínica; e escuta ativa e individualizada como ferramenta terapêutica. As participantes destacaram o uso de estratégias lúdicas, a comunicação empática, o respeito ao tempo da criança, a participação do acompanhante e a individualização dos cuidados. Na percepção das profissionais, a humanização qualifica a assistência à criança hospitalizada com desnutrição, favorecendo o acolhimento, a segurança, a aceitação do cuidado e o fortalecimento do vínculo entre criança, família e equipe de enfermagem.

Descritores: Humanização da Assistência; Enfermagem Pediátrica; Desnutrição Infantil; Criança Hospitalizada; Cuidados de Enfermagem.

Introduction

Malnutrition is a condition characterized by a deficiency of essential nutrients, which may lead to significant alterations in physical condition, vital organ function, and mental status, resulting in adverse clinical outcomes. Its causes are multifactorial, frequently interconnected with unfavorable socioeconomic conditions, chronic diseases, advanced age, or a combination of these factors[1].

Childhood malnutrition constitutes a public health problem of multifactorial origin, related to insufficient or inadequate nutrient intake, clinical conditions, food insecurity, social inequalities, and limited access to health services. In childhood, it may manifest as underweight for age or height, low weight for height, and short stature for age, reflecting, respectively, different forms and timings of nutritional impairment[1].

Although global indicators of childhood malnutrition have shown a reduction in recent decades, the magnitude of the problem remains significant. Data from the Joint Child Malnutrition Estimates report indicated that, in 2022, approximately 148.1 million children under five years of age presented with stunting, 45 million presented with acute malnutrition, and 13.7 million presented with severe acute malnutrition worldwide[2]. These data evidence the persistence of social and economic inequalities that affect child growth, development, and survival.

In Brazil, there has been a significant reduction in the prevalence of underweight and stunting among children under five years of age over recent decades. However, the persistence of cases and the occurrence of setbacks in certain population groups demonstrate that malnutrition is still associated with conditions of social vulnerability, food insecurity, and difficulty in accessing public protection and care policies[1,3].

The repercussions of malnutrition in childhood may include growth impairment, immunological alterations, increased susceptibility to infections, delayed neuropsychomotor development, higher risk of hospitalization, and greater vulnerability to mortality. Furthermore, its effects may extend into adult life, contributing to the perpetuation of the intergenerational cycle of poverty and to the occurrence of chronic diseases[4].

The hospitalization of a child with malnutrition represents a complex experience, as it is associated with clinical fragility, disruption of routine, separation from the family environment, and exposure to potentially painful or unknown procedures[3]. The child may manifest fear, anxiety, irritability, withdrawal, resistance to care, and reduced food acceptance. The family, in turn, may experience feelings of insecurity, guilt, helplessness, and concern regarding the clinical evolution[5].

In this context, the humanization of care should not be understood as a complementary or merely affective action. It constitutes an ethical, relational, and technical dimension of care, involving welcoming, adequate communication, qualified listening, respect for uniqueness, family participation, and recognition of the child as a subject of rights[6]. The Child and Adolescent Statute (ECA) establishes the absolute priority of the rights to life, health, food, and dignity, respect, freedom, and family and community coexistence [7]. These rights impose upon health services and professionals the duty to organize care practices that transcend the strictly biomedical approach, ensuring comprehensive, safe, welcoming, and child- and family-centered care.

From this perspective, the right to health provided for in the ECA is not restricted to access to services, but encompasses the right to receive qualified, ethical, humanized care, free from any form of discrimination, negligence, violence, or inhumane treatment. Thus, the humanization of care constitutes a legal and moral imperative, as it promotes respect for the child's peculiar condition as a developing person, recognizing their physical, emotional, social, cultural, and spiritual needs. The care environment should favor the construction of trust bonds between professionals, children, and family members, enabling the therapeutic process to occur in a more welcoming and less traumatic manner[7].

Furthermore, the ECA reinforces the child's right to be treated with dignity and respect, preserving their identity, privacy, and physical and emotional integrity throughout the entire care process. This implies recognizing that the child has a progressive capacity for understanding and expression and should receive information compatible with their developmental level and be encouraged, whenever possible, to participate in decisions related to their treatment. Such recognition strengthens child agency and contributes to more ethical, participatory care aligned with the principles of human rights[7].

Another fundamental aspect refers to the right to family coexistence, widely ensured by the Statute. In the context of health care, this right underlies the presence and active participation of the family during hospitalization and other moments of care, recognizing it as an essential element for the child's well-being, emotional security, and recovery. Family presence reduces feelings of fear, anxiety, and insecurity, favors treatment adherence, and strengthens shared responsibility between the healthcare team and caregivers[7].

Humanization also presupposes the professionals' commitment to developing care practices guided by empathy, dialogue, effective communication, and respect for cultural, social, and family diversities. This means considering the particularities of each child, their experiences, values, beliefs, and life context, avoiding standardized practices that disregard their individuality. Thus, humanized care materializes the principles established by the ECA by promoting care that respects the comprehensiveness of the developing human being and recognizes that the guarantee of children's rights should guide all actions developed at the different levels of health care[7].

In this sense, the realization of the rights provided for in the Statute depends not only on the existence of legal provisions but on the incorporation of these principles into the daily practice of health services. Humanization becomes an indispensable strategy to ensure that the child is

welcomed in their entirety, with respect for their dignity, progressive autonomy, biopsychosocial needs, and the right to receive comprehensive, qualified care based on the principles of full protection and absolute priority advocated by the ECA[7].

The National Policy for Comprehensive Child Health Care also guides practices aimed at child growth and development, promotion of adequate nutrition, comprehensive care for prevalent diseases, and protection of children in vulnerable situations. Grounded in the principles of comprehensiveness, equity, and humanization, the policy recognizes that childcare should consider not only the clinical aspects related to the illness process but also the psychological, emotional, social, family, and cultural dimensions that influence development and experience throughout the care trajectory. Thus, the PNAISC reinforces the need for care centered on the child and family, guided by welcoming, bonding, qualified listening, effective communication, and respect for individuality.

In the hospital context, the implementation of these guidelines becomes even more relevant, since hospitalization represents a potentially stressful and disruptive event for the child and their family. Separation from the family environment, disruption of daily routines, exposure to invasive procedures, the presence of pain, fear of the unknown, limitation of childhood activities, and the temporary separation from significant people and objects may intensify feelings of insecurity, anxiety, suffering, and vulnerability. Depending on age and developmental stage, the child may have difficulty understanding the need for hospitalization and therapeutic procedures, interpreting them as threats or punishments, which may compromise their adaptation to treatment and negatively impact their physical and emotional well-being[8].

In this scenario, the hospitalized child finds themselves in a condition of heightened vulnerability, arising not only from the disease that motivated their admission but also from the emotional, cognitive, and social fragilities inherent to the hospitalization process. This vulnerability demands from health professionals an ethical, sensitive, and welcoming stance, capable of recognizing the child as a subject of rights, with needs that transcend the treatment of the illness. Thus, humanized care should encompass strategies that minimize suffering, reduce fear, and promote safety, comfort, and trust, favoring a therapeutic environment that respects individuality and preserves child development, even in the face of the limitations imposed by disease[8].

The humanization of care in the hospital environment presupposes, therefore, the construction of interpersonal relationships based on dialogue, empathy, and mutual respect, valuing communication appropriate to the child's age and their participation, whenever possible, in decisions related to their care. It also involves the active inclusion of the family as a partner in the therapeutic process, recognizing that their presence contributes to the child's emotional stability, strengthens affective bonds, reduces the anxiety resulting from hospitalization, and favors treatment adherence. The family ceases to occupy a position of mere companion and assumes a fundamental role in the construction of shared care, strengthening shared responsibility among professionals, the child, and caregivers[8].

Furthermore, the PNAISC guidelines require articulation among different health professionals, promoting interdisciplinary care capable of integrating the biological, emotional, social, and family needs of the child. The joint action of nurses, physicians, psychologists, physical therapists, nutritionists, occupational therapists, social workers, and other members of the multidisciplinary team enables the development of more comprehensive therapeutic plans, which value the comprehensiveness of care and respond to the multiple demands of the hospitalized child.

In this context, practices such as qualified welcoming, the use of therapeutic play, maintenance of family coexistence, provision of clear information compatible with the child's developmental level, appropriate pain management, respect for the child's privacy and dignity, and the creation of more welcoming environments constitute important humanization strategies. These actions contribute to reducing the negative impacts of hospitalization, preserving child development, and promoting a safer, more respectful care experience centered on the needs of the child and their family, in accordance with the principles of the PNAISC and the Unified Health System.

In the hospital environment, these guidelines require articulation among different professionals and the adoption of practices capable of integrating the biological, emotional, social, and family needs of the child.

Nursing occupies a strategic position in this process, as it remains in continuous contact with the child and their family members. Through systematic observation, communication, care planning, and procedure execution, the nursing team can identify specific needs, reduce stressors, and favor the participation of the child and their caregiver[9].

Considering the above, the following guiding question was established: "How does nursing act in promoting the humanization of care for hospitalized children with malnutrition?". The objective was to analyze the nursing team's performance in promoting the humanization of care for hospitalized children with malnutrition.

Methodology

This is a descriptive and exploratory study with a qualitative approach, conducted through field research. Data collection took place between April and May 2025. The qualitative approach enabled the understanding of perceptions, experiences, and meanings attributed by nursing professionals to the humanization practices developed in the care of hospitalized children with malnutrition[10]. The descriptive nature allowed for the presentation of the practices reported by the participants, while the exploratory nature enabled a deeper understanding of a phenomenon still insufficiently investigated in specific pediatric hospitalization contexts[11,12].

The research was conducted in a pediatric ward of a university hospital located in the state of Rio de Janeiro. The unit has 15 beds and provides care for children aged between 29 days and 11 years, 11 months, and 29 days. Care for adolescents is provided in a specific unit, not included in the setting of this study.

Ten nursing professionals working in the pediatric ward participated in the study, including nurses, nursing residents, and nursing technicians. Professionals from both day and night shifts were included, with a minimum of two months of experience in the unit. Professionals on leave, vacation, or other absences during the data collection period were excluded.

The study was conducted in accordance with Resolutions No. 466/2012 and No. 580/2018 of the National Health Council. The research was approved by the Research Ethics Committee of the Faculty of Nursing of the State University of Rio de Janeiro, CAAE 86490125.5.0000.5282, under opinion No. 7,462,608 of March 25, 2025.

The research was authorized by the institution through the signing of a letter of consent by the nursing service head and the institution's management. Before participation, professionals were informed about the objectives, procedures, risks, and benefits of the research. All signed the Free and Informed Consent Form. Voluntary participation, the right to withdraw, anonymity, and confidentiality of information were ensured. To preserve the identity of the participants, codes N1 to N10 were used.

Data production occurred through semi-structured interviews, previously scheduled according to the participants' availability. The script consisted of two parts: the first aimed at sociodemographic and professional characterization; and the second composed of questions related to the humanization of care, the strategies used by nursing, and the perceived repercussions on the child's hospitalization experience. The interviews lasted an average of 20 minutes and were audio-recorded with the participants' authorization and subsequently transcribed in full.

The data were submitted to Thematic Content Analysis[13]. The process encompassed the stages of pre-analysis, exploration of the material, and treatment of results, including inference and interpretation. Initially, a floating reading of the transcripts was performed. Subsequently, units of meaning were identified, coding procedures were carried out, and similar contents were grouped. Afterwards, the codes were organized into thematic categories, interpreted in articulation with the scientific literature and with public policies related to child health, humanization, and nutritional care.

Results

Ten nursing professionals participated in the study, all female, aged between 25 and 54 years. Professional experience ranged from one year and three months to 34 years, while length of work in the pediatric ward ranged from three months to 12 years. Among the participants, there were nurses, nursing residents, and nursing technicians. Regarding education, variations were observed, ranging from complete high school, undergraduate nursing degree, specialization, and residency in pediatric nursing (Figure 1).

The analysis of the interviews enabled the construction of four thematic categories: Humanization practices in daily care, Humanization as a strategy for stress reduction and bond strengthening, Perceived repercussions of humanization on care acceptance and clinical evolution, and Active and individualized listening as a therapeutic tool.

The categories reveal that, for the participating nurses, humanization goes beyond the execution of care techniques, being understood as a cross-cutting practice that permeates all interactions between professionals, children, and family. The reports show that humanized care is constructed through daily attitudes that value welcoming, respect for individual needs, effective communication, and family participation, configuring itself as an essential element for the quality of pediatric care.

Humanization practices in daily care

The participants reported the use of play strategies, such as storytelling, toys, drawings, songs, conversations, and games during feeding and procedures. These actions were described as resources to bring the child closer to the team and make care less threatening. Play appeared as a therapeutic instrument capable of establishing communication with the child, respecting their developmental stage, and favoring their participation in care.

> *"Storytelling to help them eat" (N2).*

> *"We can feed her during play, feed the toy and then the child" (N2).*

In addition to play strategies, practices related to the physical protection and comfort of the child were also mentioned, such as proper bed preparation, prevention of injuries over bony prominences, care during invasive procedures, and respect for the child's and their mother's time. The testimonies demonstrate that play is perceived not only as a recreational activity but as a clinical strategy that facilitates adherence to care, strengthens the bond between professional and child, and contributes to minimizing suffering resulting from hospitalization. This understanding aligns with the perspective of humanization advocated in public health policies, in which care should consider the emotional and psychosocial needs of the child, in addition to strictly biological aspects. Another recurring aspect in the interviews refers to the adoption of practices related to the physical protection, comfort, and safety of the hospitalized child. Participants highlighted the importance of proper bed preparation, prevention of pressure injuries, careful selection of devices used, reduction of unnecessary manipulations, and performance of less invasive procedures whenever possible. These practices show that, for nurses, humanization is also expressed through technical excellence and the constant pursuit of reducing physical suffering.

Figure 1. Data from study participants: nursing professionals providing care for hospitalized children with malnutrition. Rio de Janeiro, RJ, Brazil, 2025

Pseudonym	Age (years)	Education level	Specialization or residency?	Which one?	What is your profession at the hospital?	How long have you been working in this profession?	How long have you been working in pediatric nursing?
E1	35	Complete higher education	No	-	Nurse	15 years	2 years
E2	25	Complete higher education	In progress	Pediatrics	Resident	1 year and 3 months	3 months
E3	34	Complete higher education	In progress	Pediatrics	Resident	1 year and 6 months	1 year and 2 months
E4	26	Complete higher education	Residency	Pediatrics	Resident	8 years	3 months
E5	37	Complete higher education	Specialization	Occupational health	Nursing technician	10 years	6 months
E6	35	Complete higher education	Specialization	Pediatrics and oncology	Nursing technician	18 years	6 months
E7	35	Complete higher education	Specialization	Obstetric nursing	Nursing technician	7 years	4 months
E8	51	Complete high school education	No	-	Nursing technician	30 years	12 years
E9	54	Complete high school education	No	-	Nursing technician	34 years	11 years
E10	43	Complete higher education	Specialization	Women's health	Nursing technician	15 years	8 months

"To consider using the smallest possible gauge for puncture, because malnourished children have less adipose tissue" (N3).

"To avoid excessive handling […] to hold the child, to give them affection" (N7).

The participation of the child and caregiver was also identified as a component of humanization. For the participants, allowing the child to choose, express themselves, and participate in certain stages of care favors the possible autonomy, trust, and closeness to the team. These reports reveal an expanded understanding of humanization, in which technical competence and sensitivity are not opposing dimensions but complementary. The choice of less traumatic devices, careful planning of interventions, and concern to minimize pain demonstrate that humanized care also involves clinical decisions grounded in ethical and scientific principles, aimed at preserving the child's physical and emotional integrity.

It is also observed that the participants recognize the hospitalized child as a subject in a condition of high vulnerability. Illness, hospitalization, invasive procedures, disruption of routine, separation from the family environment, and fear of the unknown make the hospitalization experience potentially suffering-inducing. In this context, small actions, such as offering comfort, using appropriate language, respecting the child's time, and providing moments of play, assume important therapeutic value, as they contribute to reducing feelings of fear, insecurity, and anxiety.

Another element strongly present in the discourse was the valorization of the child's and caregiver's participation in the care process. For the interviewees, allowing the child to make small choices, express their feelings, state preferences, and understand, within their cognitive possibilities, what will be performed during procedures represents an important humanization strategy. This participation favors the development of progressive autonomy, strengthens the feeling of security, and reduces resistance to care.

Likewise, family members were recognized as active participants in care, ceasing to occupy only the position of companions and assuming the role of partners of the healthcare team. The nurses reported that the presence of the mother or caregiver during procedures, the provision of clear information, and the welcoming of the family's doubts and anxieties strengthen trust in the service, improve communication, and favor the continuity of care after hospital discharge.

The reports also show that humanization is built through seemingly simple actions, but which hold high significance for the child and their family. The act of talking before a procedure, calling the child by name, explaining what will be done, respecting rest periods, acknowledging their emotions, and demonstrating availability to listen were described as important components of care practice. These attitudes reinforce that humanized care depends less on sophisticated technologies and more on the quality of relationships established between professionals, patients, and families.

Overall, this category shows that nurses understand humanization as a practice integrated into daily care, materialized in safe technical interventions, welcoming communication, use of play, valorization of the family, and respect for the child's uniqueness. The findings demonstrate that humanization is not restricted to isolated actions but constitutes an ethical stance that guides pediatric care and contributes to making hospitalization a less traumatic, more welcoming experience centered on the comprehensive needs of the child and their family.

Humanization as a strategy for stress reduction and bond strengthening

The interviewees recognized hospitalization as a potentially stressful experience for the child. In the case of children with malnutrition, physical vulnerability may be accompanied by greater emotional fragility and lower tolerance to procedures and routine changes. The professionals reported that talking about movies, cartoons, toys, and other child interests enables establishing rapport and making the hospital environment more welcoming.

The interviewees recognized hospitalization as a potentially stressful experience for the child, characterized by abrupt changes in routine, separation from the family environment, limitation of childhood activities, and exposure to invasive procedures, often painful and unfamiliar. In the reports, this scenario becomes even more challenging when it involves children with malnutrition, since the clinical vulnerability resulting from nutritional impairment may be accompanied by greater emotional fragility, lower tolerance to procedures, irritability, fatigue, apathy, and increased need for support. In this context, participants understand that humanization represents an essential strategy to minimize the negative impacts of hospitalization, favoring the child's adaptation to the hospital environment and promoting safer, less traumatic care experiences.

The professionals reported that establishing dialogue about topics belonging to the child's universe, such as movies, cartoons, characters, toys, favorite songs, and games, constitutes an effective strategy to initiate rapprochement with the child. By incorporating familiar elements into the hospital context, the professional reduces the formality of the care relationship, creates interaction opportunities, and favors the construction of a more welcoming and less intimidating environment.

"When I ask the child about movies, toys, or cartoons and bring that into the conversation, I manage to draw them closer to me and make the environment more welcoming, since the hospital is stressful in itself" (N4).

This report shows that humanized communication goes beyond the transmission of information about treatment, constituting a therapeutic resource capable of establishing a bond and reducing the child's anxiety regarding hospitalization. By recognizing their interests, preferences, and forms of expression, the professional demonstrates respect for child individuality and favors an interaction based on trust and welcoming. This practice also

contributes to temporarily shifting the focus away from the illness, allowing the child to be recognized in their comprehensiveness and not solely by the clinical condition that led to their admission.

Another aspect strongly evidenced in the interviews refers to the bond as a central element of humanized care. The participants highlighted that knowledge of the child, their personality, fears, and preferences enables individualization of care and reduces resistance to procedures. The bond was understood as a gradual construction, established through constant presence, attentive listening, respect for the child's time, and demonstration of affective availability.

The construction of the bond was associated with reduced fear and greater willingness of the child to participate in care.

> *"The more you get to know the child, the more it helps by creating a certain bond […]. You gain better access to them and also avoid the stress that usually makes them afraid of us" (N4).*

The participants also observed that the trust relationship favors the continuity of care and the child's perception of safety. The statement demonstrates that the rapprochement between professional and child directly impacts the quality of care. By reducing fear of the healthcare team, the possibility of cooperation during procedures is expanded, reducing episodes of intense crying, agitation, and resistance to care. Thus, the bond ceases to represent only a subjective dimension of care and becomes a therapeutic component capable of favoring the effectiveness of clinical interventions.

The testimonies also show that the trust relationship built throughout hospitalization produces perceptible repercussions for both the child and the professionals. The interviewees reported that, when a consolidated bond exists, the child demonstrates greater receptivity to the team, recognizes the professionals, seeks their presence, and manifests feelings of security regarding the care provided.

> *"The child asks for you when you're away […] and you feel that they get better" (N1).*

Although clinical improvement cannot be attributed exclusively to the established bond, the participants' perception indicates that positive interpersonal relationships favor an emotionally safer environment, contributing to greater treatment adherence, reduction of psychological suffering, and strengthening of trust between child, family, and team. This aspect reinforces that humanized care exerts influence not only on the subjective experience of hospitalization but also on the way the child faces the illness process.

Another important element identified in the interviews was the valorization of the child's participation in care. The participants reported that explaining procedures in a manner compatible with age, allowing small choices, and including the child in possible decisions strengthens their sense of autonomy and reduces insecurity regarding care interventions.

> *"When you include the child in care, you make them feel safer […] it improves their stay during hospitalization" (N7).*

Humanization presupposes the recognition of the child as an active subject in care, respecting their progressive capacity for understanding and participation. Even in the face of limitations imposed by age or clinical conditions, offering space for the child to express their feelings, state preferences, and understand what is happening contributes to reducing fear of the unknown and strengthening their trust in the healthcare team.

Another aspect that emerges from the discourse is that the bond is established not only between professional and child but also involves the family. Although this element appears indirectly in the statements, it is observed that the welcoming of family members strengthens the therapeutic relationship, expands communication, and favors the construction of shared care. When parents and caregivers perceive availability, empathy, and commitment from the team, they become more confident to participate in decisions and collaborate with the proposed interventions, equally benefiting the child.

In the specific case of children hospitalized for malnutrition, this relational dimension assumes even greater importance. In addition to the organic repercussions of the disease, these children often experience situations of social vulnerability, food insecurity, family fragility, and multiple hospitalizations, factors that may intensify emotional suffering and compromise the establishment of trust relationships. Thus, the construction of the bond becomes an indispensable therapeutic resource to favor adherence to nutritional treatment, stimulate family participation, and provide a more welcoming and less traumatic care experience.

Perceived repercussions of humanization on care acceptance and clinical evolution

In the professionals' perception, welcoming, listening, and the child's involvement in care may favor acceptance of feeding, procedures, and proposed therapies. The participants reported that calmer, more confident children tend to interact more with the team and demonstrate greater availability of care.

> *"By accepting the diet, she reduces her length of stay" (N5).*

> *"Sometimes, the child who was apathetic begins to react, interacts more, and accepts care better. This greatly influences their clinical condition" (N10).*

Although the testimonies relate dietary acceptance to clinical evolution, these findings should be interpreted as perceptions of professionals. The study did not perform measurements of length of stay, anthropometric evolution, or clinical indicators that would allow affirming a direct causal relationship between humanization and reduced hospitalization.

Active and individualized listening as a therapeutic tool

Active listening was identified as one of the main care strategies. The participants highlighted the need to know the child's life history, habits, preferences, and routine prior to hospitalization. Active and individualized listening emerged in the interviews as an important tool for the construction of humanized care centered on the child's needs. The participants highlighted that knowing the child's life history, habits, preferences, behaviors, family routine, and communication forms prior to hospitalization constitutes a fundamental step in understanding how the child experiences illness and hospitalization. In this sense, listening does not mean only hearing what the child or their family member verbalizes, but being attentive to verbal and non-verbal manifestations, behaviors, silences, facial expressions, crying, refusal, and the different ways through which the child communicates their needs.

> *"To understand how her life was before the hospital and how it is today" (N4).*

The statement from N4 highlights the importance of understanding the child beyond their current clinical condition. Hospitalization can significantly modify their routine, feeding, sleep, ways of playing, family relationships, and possibilities for interaction. By seeking to know how the child's life was before the illness and what changes occurred after admission, the professional expands their capacity to interpret behaviors and identify needs that could remain invisible when care is restricted to clinical signs and symptoms.

This perspective is particularly relevant in the care of children with malnutrition, whose condition may be associated with different biological, social, economic, cultural, and family factors. The understanding of previous eating habits, preferences, conditions of access to food, family dynamics, and the child's relationship with feeding may contribute to more individualized care. Thus, listening allows the team to recognize that food refusal, for example, should not be automatically interpreted as lack of cooperation, but may be related to illness, discomfort, altered taste, pain, fear, anxiety, routine changes, or the very way food is offered in the hospital environment.

Another element highlighted by the participants was respect for the child's and family's time. The understanding that each child has their own rhythm for establishing contact, accepting certain professionals, undergoing procedures, and experiencing new situations appears as an essential component of humanized care.

> *"To respect her time, the mother's time […] performing general care, but always respecting" (N7).*

This testimony demonstrates that the individualization of care does not mean failing to perform necessary interventions but seeking ways to execute them considering the child's particularities and limits. Respect for the child's time may represent a strategy to reduce situations of confrontation, fear, and resistance, favoring the gradual construction of trust. Likewise, recognizing the mother's or caregiver's time means understanding that the family also experiences a process of suffering and adaptation in the face of hospitalization, needing welcoming and availability from the team.

Active listening, therefore, presents itself as a tool that enables the transformation of subjective information into concrete elements for care planning. By knowing the child's preferences and individual characteristics, the professional can adapt communication styles, select play strategies, choose the most appropriate time for certain interventions, and identify resources that favor child participation. In this way, listening ceases to occupy a secondary position in the care process and becomes integrated into the therapeutic process itself.

Individualization was also related by the participants to greater safety and acceptance of treatment. By being recognized in their uniqueness and included in actions that concern them, the child may develop a greater sense of control over an experience marked by the temporary loss of autonomy and submission to different procedures. Individualization of care was related to greater safety and acceptance of treatment.

> *"It is better acceptance of treatment. When you include the child in care, you make them feel safer" (N6).*

The statement from N6 reinforces the relationship between participation, safety, and care acceptance. In the hospital environment, the child is often subjected to schedules, procedures, and decisions beyond their control. The possibility of making simple choices, expressing preferences, and understanding what will be performed may contribute to reducing the feeling of unpredictability. Thus, child participation constitutes not only a principle of respect for progressive autonomy but also a strategy to favor adaptation to the hospital environment.

In this process, communication must be appropriate to the child's developmental level. The language used by professionals needs to be understandable, concrete, and age-appropriate, avoiding terms that may generate misunderstandings or intensify fear. Explaining procedures beforehand, allowing questions, using visual and play resources, and verifying whether the child understood the information are strategies that may strengthen trust and participation in care.

The interviews also showed that individualization can occur through the incorporation of elements belonging to the child's universe. Music, for example, was mentioned as a resource used to favor feeding:

> *"There was a child who wouldn't eat at all, but with music, she would open her mouth" (N9).*

This report demonstrates how the use of a simple strategy, associated with the child's interest or response, can modify their interaction during an important moment of care. Music, in this context, may function as an element of distraction, comfort, and rapprochement, making feeding a more pleasant experience. More than the music itself, the finding reveals the importance of the professional's ability to

identify what positively mobilizes each child and incorporate that element into care.

The situation reported by N9 also shows that there is no single humanization strategy capable of responding to the needs of all children. An intervention that works for a given child may not produce the same result for another. Therefore, continuous listening and observation are fundamental to identify individualized strategies. Humanized care thus presupposes flexibility on the part of the professional, who must be capable of adapting their approach according to the responses presented by the child.

Discussion

The results demonstrate that the humanization of care was understood by the professionals as a set of relational, playful, communicational, and technical practices. This understanding expands the idea that humanizing consists only of offering comfort or establishing a cordial relationship. In the pediatric context, humanizing implies recognizing the child as a singular subject, considering their developmental stage, respecting their capacity for expression, and including the family in the planning and execution of care.

Hospitalization modifies the child's routine, restricts their autonomy, and brings them into contact with unknown people, environments, and procedures. Therefore, the way the child perceives nursing care is directly related to how professionals communicate, explain procedures, and establish trust relationships. Thus, communication adapted to the child's age and level of understanding constitutes a nursing intervention, not merely an attitude of cordiality[14].

The statements evidenced the use of games, stories, music, drawings, and toys during care. The literature indicates that play can help the child express feelings, process the hospital experience, and reduce anxiety regarding procedures. It is highlighted that playing activities favor rapprochement between professionals and children and may make the hospital environment less threatening. However, it is necessary to consider that the use of play resources should be planned according to the child's age, clinical status, energy level, and preferences[15].

In the case of children with malnutrition, the planning of play care needs to be associated with clinical and nutritional assessment. Play may favor feeding acceptance, but it does not replace nutritional status assessment, identification of the causes of malnutrition, dietary prescription, and multidisciplinary follow-up. Humanized care, therefore, must act in an integrated manner with interventions from nursing, nutrition, medicine, psychology, social work, and other involved areas[15].

The use of music or stories during feeding, mentioned by the participants, demonstrates the importance of making meals a less imposing and more meaningful experience. Hospitalized children may present with anorexia, pain, nausea, fatigue, altered taste, anxiety, and food refusal. Pressure to eat may increase resistance and compromise the child's relationship with food. In this sense, respecting their time, observing signs of discomfort, and establishing a welcoming approach are measures that may contribute to dietary acceptance.

Feeding, however, should not be analyzed in isolation. Childhood malnutrition is related to social, economic, and family determinants. Low income, food insecurity, difficulties in accessing services, and inadequate housing conditions may interfere both in the origin and in the continuity of the problem. A study conducted in Brazil reveals that childhood malnutrition in the country remains associated with structural inequalities[3]. Thus, nursing practice needs to go beyond individual guidance and articulate with the health care network and social protection systems.

Listening to the child's and family's living conditions is indispensable for discharge guidance to be feasible. Dietary recommendations that disregard income, food availability, cultural habits, and family organization may be ineffective. Nursing can contribute to identifying barriers, strengthening communication with the family, and referring situations of vulnerability to the appropriate services.

Another relevant aspect was the professionals' concern with the physical protection of the malnourished child. The mention of using the smallest gauge for punctures, reducing handling, and preventing injuries over bony prominences demonstrates the perception that malnutrition may increase cutaneous vulnerability and make certain procedures more difficult. Humanization, in this case, is articulated with patient safety, harm prevention, and individualization of techniques.

Child- and family-centered care also appeared in the testimonies. The presence of the caregiver may contribute to the child's emotional security and offer important information about their habits, communication, and preferences. Thus, shared care between nursing and family favors continuity of care and expands the caregiver's participation in the therapeutic process. This participation, however, must occur in an oriented manner and without transferring to the family responsibilities that belong to healthcare team[16].

The reports on active listening reinforce the importance of therapeutic communication. Knowing the child's life before hospitalization allows for understanding behaviors, food preferences, ways of playing, comfort strategies, and modes of expressing pain or discomfort. Listening also enables the identification of emotional and behavioral changes that may signal clinical worsening or psychological distress.

The participants related humanization to clinical improvement, greater dietary acceptance, and reduced length of stay. Although these perceptions are relevant, they must be interpreted with caution. Qualitative design allows for understanding the meanings attributed by professionals but does not allow establishing a causal relationship between humanized practices and objective clinical indicators.

To evaluate this association, studies with follow-up of anthropometric evolution, dietary acceptance, occurrence of complications, length of hospitalization, and readmissions would be necessary.

Nevertheless, the professionals' perception is important because it shows how humanization can interfere in daily care. When the child trusts the team, they tend to communicate their needs better, accept certain procedures more easily, and participate more actively in care. These relational effects may indirectly contribute to the quality of care and patient safety[14].

The National Humanization Policy guides the valorization of subjects, shared responsibility, ambience, and the shared construction of care processes[6].

In the pediatric scenario, these principles demand institutional organization, adequate staffing, availability of play materials, welcoming spaces, and continuing education. It is not enough to hold the professional individually responsible for humanization when working conditions prevent attentive and personalized care.

In this sense, continuing education should address communication with children, therapeutic play, management of food refusal, injury prevention, nutritional assessment, family approach, and identification of signs of emotional distress. Training should be accompanied by changes in work processes, allowing humanized practices to be incorporated into routine and not depend solely on the personal initiative of certain professionals.

The results demonstrate that the humanization of care was understood by the professionals as a set of relational, playful, communicational, and technical practices, articulated in the daily care of the hospitalized child. This understanding expands the perspective that humanizing consists only of offering comfort, affection, or establishing a cordial relationship with the patient. In the pediatric context, humanizing implies recognizing the child as a singular subject, considering their developmental stage, their own forms of communication, their fears, wishes, and needs, as well as their progressive capacity for participation in care-related decisions. It also implies recognizing the family as a constitutive part of the therapeutic process and establishing relationships based on respect, listening, shared responsibility, and valorization of the different dimensions that compose the illness experience.

This understanding is in line with the principles of comprehensive child health care, which presuppose that children's needs cannot be reduced to the diagnosis or clinical condition that led to hospitalization. The hospitalized child remains a child in the process of growth and development, with the need to play, communicate, establish bonds, maintain affective references, and participate, within their possibilities, in situations involving their own care. Thus, illness and hospitalization should not suspend childhood. On the contrary, care practices must be organized so as to preserve, as much as possible, the rights, dignity, progressive autonomy, and needs specific to this stage of life.

Hospitalization significantly modifies the child's routine, restricts their autonomy, and brings them into contact with unfamiliar people, environments, equipment, and procedures. Entering a hospital environment may represent a rupture with important daily references, such as home, school, toys, friends, usual feeding and sleeping schedules, and family coexistence. For the child, this rupture may be accompanied by fear, anxiety, insecurity, pain, and difficulty understanding why certain procedures need to be performed. Therefore, the way the child perceives nursing care is directly related to how professionals communicate, explain procedures, and establish trust relationships.

In this sense, communication adapted to the child's age, developmental level, and clinical condition constitutes a nursing intervention, not merely an attitude of cordiality[14]. Explaining beforehand what will be done, using understandable words, avoiding threats, allowing questions, observing the child's reactions, and verifying their understanding are strategies that can reduce unpredictability and foster a sense of security. Communication also enables the child to express pain, fear, discomfort, or refusal, allowing the team to adjust its approach. Thus, communicating with the child also means recognizing them as a participant in care and not merely as a passive recipient of interventions.

The findings evidenced the use of games, stories, music, drawings, and toys during care. The literature indicates that play can help the child express feelings, process the hospital experience, and reduce anxiety regarding procedures. Play activities favor rapprochement between professionals and children and may make the hospital environment less threatening[15]. Play, in this sense, constitutes a form of language specific to childhood and may allow the child to communicate experiences they are not yet able to express verbally. Through play, they can represent experienced situations, reproduce procedures, demonstrate fears, and experiment with coping strategies.

The use of play can also modify the child's relationship with professionals. When the nurse shares a game, tells a story, or uses a toy to explain a certain procedure, an approximation occurs that can reduce the symbolic distance between those who care and those who receive care. The professional ceases to be perceived exclusively as the one who performs potentially painful procedures and becomes associated also with experiences of welcoming, protection, and safety. This change may be especially important for children who experience prolonged or repeated hospitalizations.

However, it is necessary to consider that the use of play resources should be planned according to the child's age, clinical status, energy level, cognitive capacity, and preferences[15]. An activity that represents comfort for one child may be inappropriate for another. Likewise, in situations of greater clinical severity, fatigue, pain, or instability, the child may not be available to play. Thus, humanization should not transform play into an obligation or another task to be performed by the team but rather understand it as a resource that should be used when it makes sense for that particular child and at that specific moment of care.

In the specific case of the child with malnutrition, the planning of play care needs to be associated with clinical and nutritional assessment. Play may favor rapprochement, reduce tension, and, in certain situations, contribute to feeding acceptance, but it does not replace nutritional status

assessment, identification of the causes of malnutrition, dietary prescription, and multidisciplinary follow-up[15]. The complexity of malnutrition requires that humanization be integrated with clinical and nutritional interventions, avoiding relational practices being understood as alternatives to therapeutic conduct. Humanized care, therefore, does not oppose technique; on the contrary, it presupposes that technical competence be exercised in an ethical, individualized, and sensitive manner.

The use of music or stories during feeding, mentioned by the participants, demonstrates the importance of making meals a less imposing and more meaningful experience. Feeding occupies a central place in the care of the child with malnutrition, but may be affected by anorexia, pain, nausea, vomiting, fatigue, altered taste, gastrointestinal discomfort, anxiety, and routine changes. Furthermore, hospitalization itself may modify the child's relationship with food, either by the presentation of preparations different from those habitually consumed, or by the association of feeding with the illness environment and therapeutic procedures.

In this context, pressure to eat may increase resistance and produce negative experiences related to feeding. Respecting the child's time, observing signs of discomfort, identifying preferences, using approximation strategies, and establishing a welcoming approach may contribute to feeding being experienced in a more positive manner. However, this approach needs to be individualized and articulated with the assessment of the nutrition team and other involved professionals, especially when there is nutritional risk or need for specific intervention.

Feeding, however, should not be analyzed in isolation. Childhood malnutrition is related to social, economic, environmental, and family determinants. Low income, food insecurity, difficulties in accessing health services, inadequate housing conditions, caregiver education, and territorial characteristics may interfere both in the occurrence and in the continuity of the problem. A study conducted in Brazil reveals that childhood malnutrition in the country remains associated with structural inequalities[3]. Thus, holding the family exclusively responsible for the child's nutritional condition would be insufficient and could reinforce individualizing perspectives on a phenomenon that has multiple determinants.

From this perspective, humanized care presupposes understanding the reality in which the child is inserted. Listening to the child's and family's living conditions is indispensable for discharge guidance to be feasible and incorporated into daily life. Dietary recommendations that disregard income, food availability, cultural habits, preferences, storage conditions, family organization, and access to services may present low effectiveness. Nursing has a strategic role in identifying these barriers, in health education, in articulation with the multidisciplinary team, and in referring situations of vulnerability to the health care network and social protection services.

This social dimension reinforces that humanizing means not only improving the child's experience during the hospital stay but also understanding the conditions that contributed to the illness and those that may interfere with the continuity of care after discharge. In this sense, discharge planning should be initiated during hospitalization and constructed with family participation, considering their real care possibilities. Continuity of care depends on the articulation between hospital, primary care, specialized services, and social protection network equipment, when necessary.

Another relevant aspect was the professionals' concern with the physical protection of the malnourished child. The mention of using the smallest gauge for punctures, reducing handling, and preventing injuries over bony prominences demonstrates the perception that malnutrition may increase physical vulnerability and require greater attention during procedures. The loss of adipose and muscle tissue, skin fragility, and associated clinical conditions may demand specific care to reduce risks and discomfort.

In this case, humanization is directly articulated with patient safety, harm prevention, and individualization of techniques. The choice of appropriate devices, procedure planning, skin condition assessment, reduction of unnecessary manipulations, and care with positioning are manifestations of care that recognizes the vulnerability of that child. Thus, humanization should not be dissociated from the technical-scientific quality of care. Technically safe practice, when performed with respect, communication, and attention to individual needs, also constitutes a humanized practice.

The vulnerability of the malnourished child, therefore, must be understood in a multidimensional manner. It is not limited to nutritional impairment or greater susceptibility to clinical complications, but also involves emotional, family, and social aspects. The child may simultaneously experience the effects of illness, hospitalization, and social conditions that hinder recovery and continuity of care. Recognizing these different dimensions is essential to avoid fragmented care and favor a comprehensive approach.

Child- and family-centered care also appeared in the testimonies. The presence of the caregiver may contribute to the child's emotional security and offer important information about their habits, communication, preferences, fears, and comfort strategies. The family constitutes an important source of knowledge about the child and may assist the team in interpreting behaviors that, at certain moments, may not be easily understood by professionals.

Thus, shared care between nursing and family favors continuity of care and expands the caregiver's participation in the therapeutic process[16]. However, this participation must occur in an oriented and respectful manner, without transferring to the family responsibilities that belong to the healthcare team. Humanizing does not mean delegating professional care to the caregiver, but building a partnership in which each subject has their role recognized. The team remains responsible for technical care and care decisions, while the family may collaborate based on their knowledge about the child and their affective and participatory availability.

The reports on active listening reinforce the importance of therapeutic communication. Knowing the child's life prior to hospitalization allows for understanding behaviors, food preferences, ways of playing, comfort strategies, and modes of expressing pain or discomfort. This dimension of listening expands the professional's capacity to individualize care, as it allows understanding the child beyond the diagnosis recorded in the medical record.

Listening also enables the identification of emotional and behavioral changes that may signal psychological distress or alterations in clinical status. A child who usually interacts and becomes overly quiet, for example, may be expressing pain, fatigue, fear, sadness, or clinical worsening. Likewise, persistent food refusal may require investigation of physical, emotional, and environmental factors. Observation associated with qualified listening, therefore, constitutes an important resource for the comprehensive assessment of the child.

This perspective reinforces the nurse's role as a professional who remains close to the child and accompanies different moments of the hospitalization process. Proximity favors the identification of subtle changes and allows for the establishment of trust relationships that facilitate communication. However, for this to occur, it is necessary that work organization provides time and availability for engagement with the child, avoiding care being reduced to the completion of tasks and procedures.

The participants related humanization to clinical improvement, greater dietary acceptance, and reduced length of stay. Although these perceptions are relevant and express the professionals' experience in daily care, they must be interpreted with caution. To evaluate this association, studies with specific designs and follow-up of indicators such as anthropometric evolution, dietary acceptance, occurrence of complications, length of hospitalization, need for nutritional support, functional recovery, and readmissions would be necessary.

Nevertheless, the professionals' perception is important because it shows how humanization can interfere in daily care. When the child establishes a trust relationship with the team, they may communicate their needs better, demonstrate less resistance to certain procedures, and participate more actively in care. These relational effects may indirectly contribute to the quality of care, patient safety, and a less traumatic hospital experience[14]. Therefore, although causality regarding clinical outcomes cannot be affirmed, the findings support the relevance of the relational dimension as a component of the quality of pediatric care.

In this sense, the findings allow expanding the discussion beyond the individual responsibility of the professional. Although attitudes such as listening, conversing, playing, and welcoming depend on each worker's stance, their continuity and quality are related to institutional conditions. Work overload, insufficient staffing, high care demand, lack of materials, absence of adequate spaces, and pressure for productivity may limit the possibility of establishing more individualized relationships. Thus, humanization needs to be understood also as an institutional and political responsibility, and not merely as a personal attribute of professionals.

Continuing education constitutes, in this scenario, a fundamental strategy. Training processes should address communication with children, qualified listening, therapeutic play, management of food refusal, assessment of the needs of the malnourished child, injury prevention, safety during procedures, family approach, children's rights, and identification of signs of emotional distress. However, training professionals is not enough if changes are not accompanied by a review of work processes. It is necessary to create conditions for what is learned to be effectively incorporated into daily practice.

Continuing education can also favor spaces for reflection on concrete situations experienced by the team. Case discussions, conversation circles, analysis of conflict situations, collective construction of protocols, and sharing of experiences may contribute to professionals identifying barriers and potentialities for humanization. This perspective values the knowledge produced in daily work and allows the team to develop contextualized strategies for the needs of the population served.

Another point that emerges from the analysis is the need to understand humanization as a continuous process and not as a set of isolated actions. Telling a story, offering a toy, or using a song may represent a humanized practice, but its effectiveness depends on the relationship established with the child and the articulation with other dimensions of care. Care cannot be considered humanized simply because it uses play resources if, simultaneously, it disregards pain, does not respect privacy, limits family participation, or performs procedures without adequate communication.

Thus, the results point to an expanded conception of humanization, in which the affective dimension, technical competence, safety, communication, child participation, family presence, and multidisciplinary articulation are inseparable elements. This conception is particularly pertinent in the case of the malnourished child, whose vulnerability condition demands a perspective that goes beyond the treatment of nutritional deficiency and encompasses the conditions involved in their illness and recovery process.

The analysis also allows recognizing that humanized care can function as an articulating element between different professionals and fields of knowledge. The identification of feeding difficulties, for example, may require joint action of nursing, nutrition, medicine, psychology, and social work. Nursing, due to its proximity and continuity of contact with the child, can act as an important articulator of these needs, sharing relevant information and contributing to the construction of an integrated care plan.

Therefore, the results reinforce that humanizing the care of hospitalized children with malnutrition means recognizing their vulnerability without reducing them to the disease, preserving their condition as a child, respecting their rights and singularities, and constructing care strategies that consider their history, family, and social context. Humanization does not replace technical and

scientific care but qualifies the way this care is provided. It is about integrating science, technique, ethics, and sensitivity into a practice that recognizes that each procedure takes place on a body that has history, feelings, relationships, and rights.

Thus, it is possible to understand that humanization can be considered a cross-cutting dimension of the quality of pediatric care. Its effectiveness requires not only sensitized professionals but also institutions committed to adequate working conditions, continuing education, family participation, welcoming environments, and organization of care processes. In the case of children with malnutrition, this commitment must be even more comprehensive, articulating clinical and nutritional care, protection of rights, reduction of vulnerabilities, and strengthening of the care network. Thus, humanization ceases to be understood as a complementary component of care and becomes a guiding principle of comprehensive, safe, ethical care centered on the child and their family.

Final Considerations

This study allowed for the understanding that, in the perception of nursing professionals, humanization constitutes an essential part of care for hospitalized children with malnutrition. The practices reported involved the use of play resources, empathic communication, active listening, respect for the child's time, caregiver participation, and the adoption of measures aimed at physical and emotional protection.

Hospitalization can be an experience marked by fear, anxiety, disruption of routine, and temporary loss of autonomy. When associated with malnutrition and conditions of social vulnerability, it becomes even more complex. In this scenario, nursing plays a fundamental role in building trust relationships, identifying the child's needs, and articulating care with the family and other professionals. The testimonies suggest that welcoming and individualized attention may favor the acceptance of feeding, procedures, and treatment. However, such repercussions should be understood as perceptions of the participants, and it is not possible to state, based on this study, that humanization alone reduces length of stay or determines clinical recovery.

It is concluded that humanization should not be treated as a complement to care, but as an ethical, technical, and therapeutic component of nursing care. For its realization, institutional policies, continuing education, adequate working conditions, and articulated multidisciplinary action are necessary, ensuring for the hospitalized child with malnutrition a dignified, safe, welcoming, and needs-centered care.

The importance of nursing in the construction of humanized, safe, and individualized pediatric care is reinforced. Listening, welcoming, the use of play strategies, adequate communication, and family participation may contribute to making hospitalization less threatening and favoring care acceptance. The study also provides support for the development of continuing education actions focused on humanization, nutritional care, and child- and family-centered care.

It is recommended that institutions develop protocols and care strategies that include nutritional assessment, injury prevention, management of food refusal, therapeutic use of play, and articulation with the care network after discharge.

This study presents as a limitation its conduct in a single pediatric ward of a university hospital, which restricts the transferability of the findings to other institutional contexts. The small number of participants should also be considered, although it is compatible with the qualitative nature of the investigation.

Data production was based on the reports of nursing professionals, not having included the perspective of children, family members, or other members of the multidisciplinary team. Furthermore, clinical or nutritional indicators capable of objectively measuring the relationship between humanization practices and the child's evolution were not analyzed.

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