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Health promotion and disease prevention: perspectives of primary care nurses

Promoção da saúde e prevenção de doenças: perspectivas de enfermeiros da atenção básica

Promoción de la salud y prevención de enfermedades: perspectivas de enfermería de la atención básica

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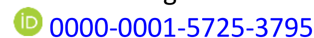
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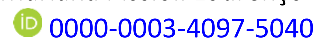
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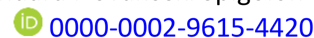
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ABSTRACT
Objective: to verify the perceptions and practices of nurses working in primary health care about health promotion and disease prevention actions. **Method:** qualitative research carried out with 15 nurses who coordinate family health teams. The interviews were processed by the IRaMuTeQ® software and submitted to the content analysis technique. **Results:** five classes emerged: Public involved, range of activities developed and their periodicity; Adversities for carrying out health promotion and disease prevention actions; Users' perspective on Health Education; Permanent Education Practices in Health; and Behavioral change of users from health promotion and evaluation of results. **Conclusion:** for nurses, promotion and prevention actions are positive for the community, optimizing self-care. Adversities such as lack of time, deficit in the professional staff and overload were reported.
Descriptors: Disease Prevention; Health promotion; Primary Care Nursing; Nursing.

RESUMO
Objetivo: verificar as percepções e as práticas de enfermeiros atuantes na atenção primária à saúde acerca das ações de promoção da saúde e prevenção de doenças e agravos. **Método**: pesquisa qualitativa, realizada com 15 enfermeiros coordenadores de equipes da saúde da família. As entrevistas foram processadas pelo *software IRaMuTeQ® e* submetidas à técnica de análise de conteúdo. **Resultados**: cinco classes emergiram: Público envolvido, gama de atividades desenvolvidas e suas periodicidades; Adversidades para a realização de ações de promoção à saúde e prevenção de agravos; Perspectiva dos usuários quanto a Educação em Saúde; Práticas de Educação Permanente em Saúde e Mudança comportamental dos usuários a partir da promoção da saúde e avaliação dos resultados. **Conclusão:** para os enfermeiros, ações de promoção e prevenção são positivas para a comunidade, otimizando o autocuidado. Adversidades como falta de tempo, *déficit* no quadro profissional e sobrecarga foram relatadas.
Descritores: Prevenção de Doenças; Promoção da Saúde; Enfermagem de Atenção Primária; Enfermagem.

RESUMÉN
Objetivo: verificar la percepción de los enfermeros que trabajan en la atención primaria sobre las acciones de promoción de la salud y prevención de enfermedades. **Método:** investigación cualitativa, realizada con 15 enfermeros coordinadores de la salud de familia. Las declaraciones fueron procesadas por el *softwareIRaMuTeQ®* y sometidas a la técnica de análisis de contenido. **Resultados:** surgieron cinco clases: Público involucrado, abanico de actividades desarrolladas y su periodicidad; Adversidades para la realización de acciones de promoción de la salud y prevención de enfermedades; Perspectiva de los usuarios sobre educación para salud; Prácticas de educación permanente para salud y Cambio de comportamiento de los usuarios basado en la promoción de la salud y evaluación de resultados. **Conclusión:** para las enfermerías, acciones son positivas para la comunidad, optimizando el autocuidado. Informaron adversidades como falta de tiempo, escasez de profesionales y sobrecarga
Descriptores: Prevención de Enfermedades; Promoción de la Salud; Enfermería de Atención Primaria; Enfermería.

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INTRODUCTION

Primary Health Care (PHC) is characterized by the set of individual, family and collective actions that involve attributions common to the entire team of professionals, especially nursing, in order to ensure health promotion and prevention of injuries and diseases, aiming at comprehensive care and maintenance of the health of the enrolled population[1].

Theorizing about PHC was the result of debates held in Alma-Ata in 1978, bringing the concept of integral health - inseparable from socioeconomic and universal issues, as a right for all. However, during its application, especially in Latin American countries, distortions occurred that moved away from the reality of the developed concept, significantly weakening primary services, maintaining biomedical care as a guideline for health institutions and distancing itself from preventive care[2].

Thus, the concept of health promotion has undergone numerous changes since its first mention, being defined as an intersectoral process of training the individual and the community to improve their quality of life. Making users active in health processes, encouraging self-care and interventions in the social determinants of health[3].

In turn, the prevention of diseases and injuries is characterized by the non-development of specific conditions and the search for knowledge about the natural history of diseases. Studies in this area can provide interventions directed by nurses and other team members, as well as managers, focused on points related to the incidence of diseases, considering epidemiological factors associated with morbidity and mortality, in order to mitigate them[4].

In this context, the National Health Promotion Policy (NHPP) was implemented in Brazil, which reinforces the importance of raising awareness and training health professionals and managers on this topic. It also highlights special attention to health promotion care throughout the national territory, with a focus on community instrumentation and intersectoral action[5].

Several advances in quality of life and in the health-disease situation could be glimpsed in Brazil during the implementation of PHC, especially when the focus was on promoting actions and in line with the NHPP, it is noteworthy that these actions are carried out by multiprofessional team, but with the strong presence of nursing work. However, vicissitudes and deficits in community and citizen care are still observed, which can generate undesirable outcomes[6,7].

Professionals who work in PHC may have low skills and difficulties in implementing health promotion and disease prevention actions, such as in combating endemic diseases, nutrition, pharmaceutical aspects, among others. This shows the discrepancy between population demands and the provision of services[8]. Still, there are deficits in health education processes, especially with an emancipatory approach, which would enable better professional performance to promote the health of the population[5].

The different perspectives on public policies, especially those that concern health promotion practices and disease prevention, must be understood by professionals working in the Unified Health System, especially nursing professionals who make up the largest professional category in health services and have health education and promotion in the scope of their work, in order to improve and qualify work practices and implement public policies[1].

Considering the current production of knowledge related to the role of nurses in health promotion and disease prevention, knowing their contribution and role in community health and in PHC[1], it is opportune to understand, from the perspective of these professionals, how practices take place in this environment. Its findings will make it possible to expand the scientific production on public health in practice and, indirectly, to point out how the materialization of this public policy takes place by the professionals who allow its implementation and how it turns to the community from their perspective (2,5- 7).

Thus, the research question of this study was: what are the knowledge and actions of nurses who work in PHC on health promotion and prevention of diseases and injuries? From this, the objective was to verify the perceptions and practices of nurses working in primary health care about health promotion and disease prevention actions.

METHODS

This was a descriptive, exploratory research with a qualitative approach, carried out with

nurses who worked in the PHC and coordinated Family Health teams (FHt) in a municipality in the northwest region of the State of Paraná, Brazil. The National Primary Care Policy (NPCP)[1] was used as a theoretical framework, due to the inclusion of research participants within the context enacted by this public policy and for addressing issues related to health promotion and disease prevention.

The inclusion criterion was: working as nurse coordinator of the FHt and being over 18 years old. The exclusion criteria were: working for less than six months in the PHC (the justification for this delimitation of working time is that this time is considered to be the minimum period for the practice to add experiences in actions with the population); being diverted from their duties or away from work activities during the data collection period.

The selection of participants took place with the support of the management of the Family Health Strategy teams in the municipality, which provided data on the nurses, such as: name, e-mail addresses, Basic Health Unit (BHU) in which they worked and if they were active or away from their work activities.

After surveying the target audience, the pre-established inclusion and exclusion criteria were applied. Of the 25 FHt present in the municipality, 22 had graduates in nursing as coordinators. Of these, one was diverted from his duties and the other was away for medical reasons, resulting in 20 professionals eligible to participate in the study.

Data collection was carried out in April and May 2020 and took place through audio-recorded interviews, which took place in a reserved room chosen by the participant at the BHU of origin. Thus, we used a voice recorder and an interview script divided into two parts: the first with sociodemographic questions, in order to characterize the participants; and the second composed of the following questions in order to identify their perception and practices: What health promotion actions are carried out by your team?; What disease prevention actions are carried out by your team?; How do you believe the population perceives these actions?; How do you and your team evaluate these actions?; What do you believe could change to qualify the realization of these actions? The mean duration of the interviews was 8 minutes and 17 seconds, ranging from 4 minutes and 11 seconds to 12 minutes and 45 seconds.

The data referring to the characterization of the participants were tabulated in the computer software Microsoft Excel 2010® and analyzed using simple descriptive statistics. For the qualitative analysis, the interviews were fully transcribed into a document in Microsoft Office Word®, organized and analyzed in terms of lexical content using a qualitative analysis software, called Interface de Rpour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ ®), version 0.7 alpha 2.

IRaMuTeQ® is anchored in the R software to perform statistical calculations from textual corpus, its fractions, the text segments, and the words that compose them, evidencing the frequency and establishing statistical relationships between the words, quickly and effectively. Furthermore, it allows the textual analysis of data in five different modalities: textual statistics, word cloud, Descending Hierarchical Classification (DHC), similarity analysis and correspondence factor analysis[9].

The DHC was used in this study. This method divides the textual corpus into thematic axes, called "classes", allowing the data to be analyzed. This process takes place through the fragmentation of the corpus into text segments, which are grouped according to the vocabularies with the highest frequency and highest chi-square values in the class, evidencing the most significant words for the qualitative analysis of the results[9].

The classes, generated from the text segments, gain meaning based on the (re)reading of them and the most prevalent words themselves, allowing their naming according to their content and analysis from the thematic axes through the perspective of analysis of content, forming the categories presented in the results[10].

To maintain the confidentiality of the participants, they were identified as "Nur", from the word "nurse", and the numeral was added according to the order in which the interviews were carried out, for example: Nur 1, Nur 2, Nur 3, and so on.

In order to carry out this research, all the guidelines established by the ethical standards in force in research with human beings were met, according to Resolution 466/2012 of the National Health Council, and was approved by the Ethics

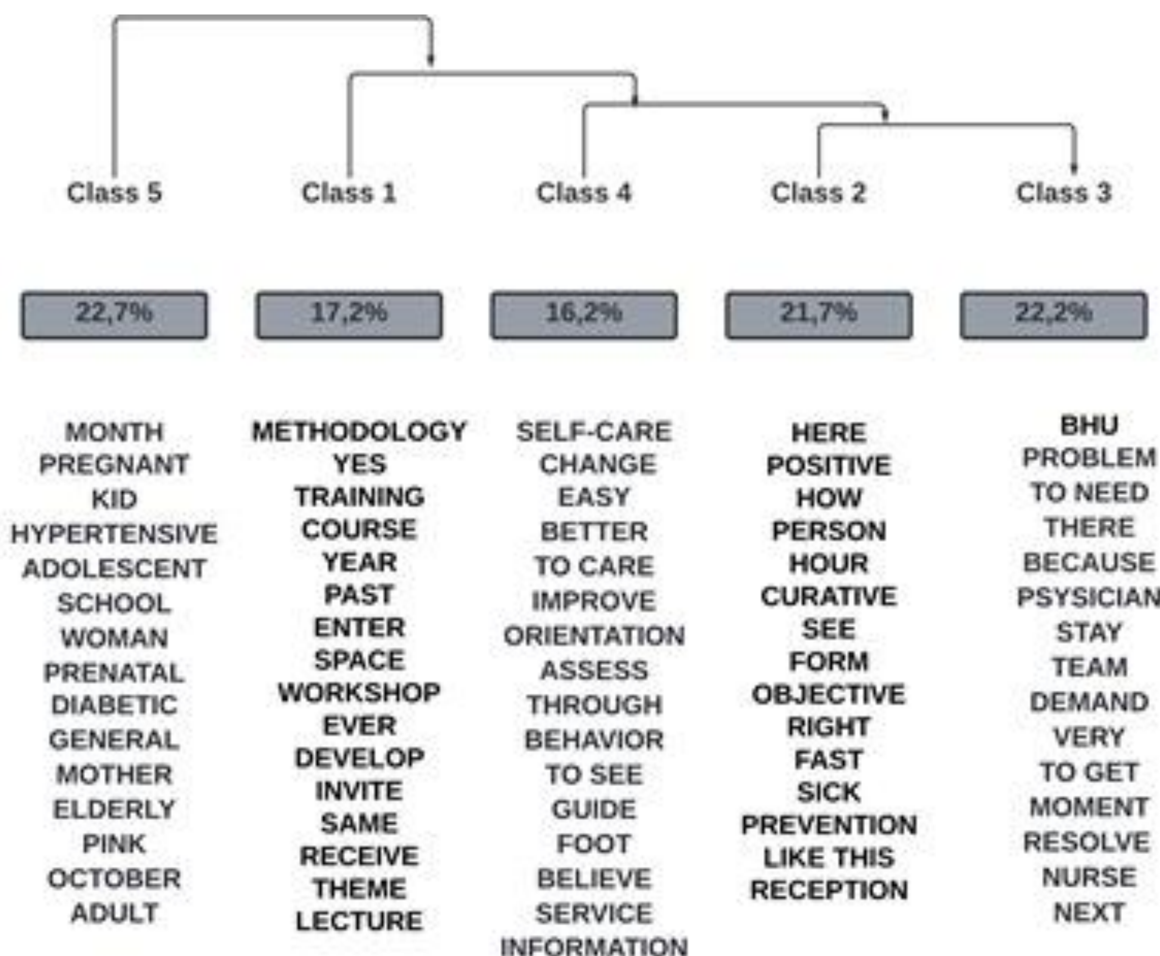
Committee of the State University of Maringá, under opinion number 3,091. 456/2018.

RESULTS

Of the 20 eligible nurses, 15 voluntarily agreed to participate in the research. Their age ranged from 26 to 44 years and the majority (n=14) of the participants were female. As for education, four had a postgraduate degree; the mean time since graduation was 10.4 years; and the mean time working in PHC was 9.6 years.

The DHC dendrogram (Figure 1), from the analysis of the corpus "Perspectives of Primary Care Nurses About Health Promotion and Disease Prevention Actions", originated five classes, represented in Figure 1. The analysis of related words within the classes, identified and interpreted in the context of the textual corpus, it allowed the categorization of the classes generated by the software and their subsequent analysis.

Figure 1. Dendrogram from the analysis of the textual corpus.



Source: The authors, organized by IRaMuTeQ® software, 2020.

In order to present the data in a didactic way (Box 1) the classes received nomenclatures, and are presented according to their percentage, and with those with significant associations (p<0.001).

Figure 2. Statistical analysis from the textual corpus. Paranavai, Paraná, Brazil. 2020 (N=15).

Class number	Class nomenclature	% of class in descending order	Lexicographic Analysis		
			Words (p<0.001)	X^2	(%)
5	Public involved, range of activities developed and their periodicity	22.7	Month	53.97	94.12
			Pregnant	44.99	70.00
			Kid	43.43	100
			hypertensive	34.17	77.78
			Adolescent	32.06	100
			School	27.14	90.00
			Woman	23.50	88.89
			Childcare	23.27	76.92
			Prenatal	19.88	75.00
			Diabetic	19.56	63.16
			General	17.44	100
			Mother	17.44	100
			Elderly	15.84	57.00
3	Adversities for carrying out health promotion and disease prevention actions	22.22	BHU	26.04	59.62
			Problem	25.40	100
			To need	24.24	88.89
			There	21.10	71.43
			Because	16.99	43.75
			Physician	16.92	85.71
2	Users' perspective on Health Education	21.72	Here	18.49	100
			Positive	18.49	100
			How	17.03	62.50
1	Continuing Education in Health Practices	17.17	Methodology	24.74	100
			Yes	22.68	58.82
			Training	19.04	83.33
			Course	19.09	83.33
			Year	15.22	58.33
4	Behavioral change of users based on health promotion and evaluation of results	16.16	Self-care	33.10	100
			Change	31.31	87.50
			Easy	20.60	83.33
			Better	16.36	71.43
			To care	15.80	100

Source: The authors, organized by the IRaMuTeQ® software, 2020.

The class that obtained the highest percentage, and consequently the highest representation in the textual corpus, was number 5 (22.7%), called "Public involved, range of activities developed and their periodicity". This class expresses the population groups that participate in the actions developed by the teams, highlighting the groups of pregnant women, children, hypertensive patients, adolescents, women, diabetics and the elderly.

It also explains what activities are carried out, as well as the frequency of these actions, as can be seen from the statements: "Usually once a month with each group. Smoking is usually fortnightly, when groups are formed. Childcare is weekly [...] but once a month the children are followed up by childcare and are evaluated.(Nur07)". "From the care of pregnant women to the elderly, then all life cycles. Health promotion and prevention activities with pregnant women, children, adolescents, women, adults, men, the elderly... (Nur01)".

The second most representative class in the corpus was number 3 (22.22%), entitled "Adversities for carrying out health promotion actions and disease prevention". Through the analysis of the speeches, it can be seen that nurses attribute the high demand at the BHU, the consequent lack of time and the reduction of human resources to the low performance in health promotion and disease prevention activities.

This context is presented in the following statements: "Much of my work is spontaneous demand, I have to keep screening patients, and solve so many administrative problems, that I could be implying all this energy, all this strength, in

prevention and promotion” (Nur02). “It's a lot of problems, a lot to solve, a lot of maintenance [...] if there was a coordinator who took care of the BHU, of all the internal problems, the FHT nurse would be able to perform a more effective action in relation to the care of the community” (Nur06).

Class 2 (21.72%), in turn, represented the nurses' apprehension about the users' view, and was entitled “Users' perspective on Health Education”. It is noted that the nurses believe that the community receives the actions in a positive way, in addition to the users who attend the BHU already knowing the routine and work of the professionals, as shown in the following excerpts: “They like it a lot, their feedback is very positive” (Nur02). “The population is well educated here, in the morning it is the curative part and in the afternoon it is prevention, so in the afternoon there are no sick people, nor looking for more, because they already know that the afternoon is just the programs” (Nur13). “I think the most, at least the audience that joins, they see it as something positive. It is not a large audience, but those who participate realize that it has some objective” (Nur05).

Class 1 (17.17%) addresses professional preparation to carry out health promotion and disease prevention actions, issues that pertain to the National Policy on Permanent Education in Health and, therefore, was entitled "Permanent Education Practices in Health”.

It is noteworthy that employees receive training to work with the community through bipartite municipal and regional management, however, traditional methodologies are predominant, disregarding the real demands observed in the capillarity of care. As for the actions that make up the team's work process, dialogic and participatory strategies are highlighted, through the sharing of knowledge, especially in case discussions.

The actions received by the nurses are expressed in the excerpts: “Yes, several trainings. Passive methodologies that we only listen to and lectures, but it is difficult for us to have a group” (Nur09). “We participate a lot in lectures [...] but it often gets very boring, always the same methodology, always lectures, talking, talking, talking” (Nur07). “Yes, little, rarely, but yes. In meetings, we usually choose specific topics to discuss, sometimes we see with them what they would have questions about and we discuss it” (Nur12).

Another aspect addressed by nurses was the stimulation of self-care by users after the actions developed by the team, observed in class 4 (16.16%), named “Behavioral change of users based on health promotion and evaluation of results”. From the nurses' perspective, users change their life habits based on health education, evaluating the effectiveness in improving self-care and healthy behavior, as shown below: “Yes, we see a change in behavior. Both in cares, in self-care, I see that they improve” (Nur02). “We evaluate self-care, mainly through home visits, when the CHA makes home visits and he knows that the patient himself knows how to take care of himself, if he fails in self-care” (Nur11).

Discussion

According to the NPCP, PHC teams must develop all activities that meet the population demand in their assigned territory, prioritizing the population with a higher degree of vulnerability and epidemiological risk[1]. It stands out in the discourse of the nurses interviewed for vulnerable and programmatic populations, such as pregnant women, the elderly, children, and hypertensive and diabetic patients.

PHC in Brazil, as well as in other emerging economy countries, has an expanded concept of health, but it started with a basic package of services, focusing on specific conditions, distancing itself from the concept envisioned in Alma-Ata, which contemplated the entire complexity and integrality of the health process. These packages can weaken and fragment the concept of health and the performance of the public system, as they focus on already established conditions, such as care for the chronically ill and care during pregnancy and childcare[11].

The nurses' speeches expressively bring the practice of actions aimed at maternal and child care, evidenced in the fifth class through the words pregnant, child, childcare, prenatal care and mother. Although there is relevance and great focus on the theme in PHC[12], from the perspective of the various actors involved in this process, the presence of flaws in the health care of this population, such as interruption in monitoring, lack of guidance, services little accessible and deficits in the groups of pregnant women is highlighted[13,14].

The fight against chronic non-communicable diseases (CNCD), such as Systemic Arterial Hypertension and *Diabetes mellitus*, is carried out by nurses within different contexts in health services around the world. The concept of user empowerment through educational practices, creativity and innovation in actions, longitudinal care, and the reorientation of services enhances care for these users and are present in nurses' praxis[15].

With regard to the health of the elderly, the FHt perform fundamental activities for the maintenance and promotion of the health of this population, nursing performs preventive actions, monitoring of health conditions and coordination of care. Actions with this audience have vast potential, such as reducing the incidence of CNCD, mitigating social isolation, strengthening sociability and community social ties, encouraging self-care and lifestyle changes, as well as maintaining autonomy and independence[16].

Nurses voice difficulties in carrying out health promotion and disease prevention actions in the community, due to work overload, lack of time for these activities and insufficient provision of human resources available to carry out these activities.

According to the NPCP[1], teams must be composed of physicians, nurses, nursing technicians/assistants and community health agents (CHA). It is also recommended the inclusion of Primary Care Managers, who should not be linked to the teams and who carried out technical-management actions, aiming at the qualification of health care for the enrolled population.

The nurses interviewed reported not having managers, overloading them with technical, managerial and administrative functions and making the attention to the enrolled population deficient. This characteristic is also identified in health units in the state of São Paulo, in which all PHC managers were not dedicated only to this function[17].

Factors extrinsic to nurses, such as the lack of sufficient human resources to carry out health promotion actions, operationalization of activities outside their scope, work overload, lack of time, hierarchy and professional (de)valuation, among others, influence in the low quality and non-execution of activities by the FHS[17-19].

Also according to the NPCP, community participation in health services is a guideline that aims at social control of PHC, expanding the autonomy of individuals and the community, expanding the confrontation with health determinants and conditions through the articulation of society devices and intersectoral action with community organizations[1].

A Swedish study that investigated the concern, expectation and satisfaction of PHC users and professionals found that most users felt satisfied with the actions performed, while a smaller number of professionals believed that their patients were satisfied. This data shows the disparity in the perceptions of the agents involved in the health process and also the high expectations that professionals attribute to their practices[20].

Nurses reported that users, after participating in health promotion and disease prevention actions, changed their life habits, managing health care more efficiently. This data corroborates the finding in a literature review of articles from 1996 to 2012, in which, for the most part, changes in self-care and life habits were noticed after attending health promotion actions[12].

The home visit (HV) was identified as a strategy for health assessment by the participants. It is worth noting that, according to the NPCP, HV is a common assignment for all professionals who make up the team[1], although this activity is primarily developed by the CHA[18].

The individuals' domicile represents a privileged *locus* for health assessment, where economic, social and cultural characteristics - fundamental determinants of health - can be observed. The CHA, due to the bond with the families in his area of expertise, stands out as a fundamental part of this evaluation and intervention process[21].

In contrast to the nurses' report, a literature review showed that PHC service users are dissatisfied with family and community guidelines, which are fundamental for society's autonomy and participation in health processes. It also reveals that care actions are still being developed without privileging people's participation and the community context where they live[22].

The training of nurses and other health professionals, in order to act in accordance with the population demands of the Unified Health System (SUS), is essential for the quality of health management and quality of care. Meaningful

learning is, in this context, a key principle for transforming the reality of the work process and consequent improvement in the quality of services provided by the individual and the health team[23].

Health education must be guided by the criticality of work-related processes, finding, through reflection on practices, problems in everyday life that can be solved[23]. Therefore, it is essential that professionals are inserted in a dialogic and participatory way in the pedagogical process, problematizing the reality in which they are inserted, so that, in this way, education is meaningful, transformative, democratic and active[24]. Still, spaces need to be offered within the work process for the sharing of knowledge and practices among team members, making the PHE effective.

In the context of the SUS, the National Policy on Permanent Health Education (NPPHE) is available, an educational health strategy aimed at Brazilian health professionals, which still encounters obstacles to its implementation in the national territory, with emphasis on the low priority given by managers to permanent education, bureaucratic obstacles, such as: difficulty of states and municipalities in the execution of resources and legal restrictions for their use, large territorial extension, difficulty of managers in envisioning the NPPHE as a public policy[25].

CONCLUSION

From the analysis of the interviews, it can be seen that, from the perspective of PHC nurses, all life cycles are covered by the actions carried out by the team, and these are glimpsed within the priority groups for the development of activities.

From the perspective of professionals, individuals who effectively participate in the actions are able to transform their life habits, improve their self-care practices and, through home visits, these behavioral changes can be evaluated. Still, they believe that the community perceives the activities as positive and values them.

Although the actions are involved in positive aspects, some adversities are faced to carry them out, and are these: the high demand for work, the insufficient number of professionals and the consequent lack of time weaken the process. Also, health education practices, although frequent by management, are not implemented in a democratic way and are carried out in a traditional and banking way.

The results of the study contribute to nursing care by demonstrating that systematized health education actions can contribute to improving the quality of life of people served in PHC, and that the work process needs to be organized for this to occur.

As a weakness of the study, it is highlighted that it was conducted with a group of nurses who live in a specific reality, making it impossible to generalize the results; in addition, the PHC is configured as a space for multidisciplinary action, and that only one professional category was interviewed, thus weakening the understanding of the entire process and the actors involved. It is suggested that health promotion and disease prevention practices be investigated in other contexts, contemplating different professional categories.

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