

Planning actions that contribute to the practice of quaternary prevention in primary health care

Planejando ações que contribuem para a prática da prevenção quaternária na atenção primária à saúde

Planeando acciones que contribuyen para la práctica de la prevención cuaternaria en la atención primaria de la salud

ABSTRACT

Objective: to reflect with the team and develop a plan of actions that contribute to the practice of Quaternary Prevention in Primary Health Care. **Method:** Appreciative Inquiry with the participation of nine professionals and five meetings, corresponding to the phases: discovery, dream, design and destiny. The meetings corresponding to the last three phases were explored. Field diaries and audio records of the testimonies were used. Thematic Content Analysis was carried out. **Results:** three categories emerged: Organization of teamwork; Qualification of work processes; Development of health education actions. Actions were planned that contribute to practices aimed at Quaternary Prevention, such as permanent education actions, qualified listening, guarantee of access, collaborative work and recognition of the territory. **Conclusion:** dialogue and reflections about unnecessary/inappropriate practices and interventions carried out in the services and their risks were promoted, incorporating an action plan in this direction.

Descriptors: Primary Health Care; Quaternary Prevention; Social Medicine; Medicalization; Unified Health System.

RESUMO

Objetivo: refletir com a equipe e desenvolver um planejamento de ações que contribuam para a prática da Prevenção Quaternária na Atenção Primária à Saúde. **Método:** Pesquisa Apreciativa com a participação de nove profissionais e cinco encontros, correspondentes as fases: *discovery* (descoberta), *dream* (sonho), *design* (planejamento) e *destiny* (destino). Foram explorados os encontros correspondentes às três últimas fases. Diários de campo foram utilizados, além da gravação dos depoimentos em áudio. Realizou-se a Análise Temática de Conteúdo. **Resultados:** emergiram três categorias: Organização do trabalho em equipe; Qualificação dos processos de trabalho; Desenvolvimento de ações de educação em saúde. Foram planejadas ações que contribuem para práticas voltadas à Prevenção Quaternária, como ações de educação permanente, escuta qualificada, garantia do acesso, trabalho colaborativo e reconhecimento do território. **Conclusão:** promoveu-se o diálogo e reflexões sobre as práticas e intervenções desnecessárias/inapropriadas realizadas nos serviços, bem como seus riscos, incorporando-se um planejamento de ações nessa direção.

Descritores: Atenção Primária à Saúde; Prevenção Quaternária; Medicina Social; Medicalização; Sistema Único de Saúde.


RESUMEN

Objetivo: reflexionar con el equipo y desarrollar un plano de acciones que contribuyan para la práctica de la Prevención Cuaternaria en la atención Primaria de la Salud. **Método:** Investigación Apreciativa con la participación de nueve profesionales. Realizada en cinco reuniones, las cuales correspondieron a fases: *discovery* (descubrimiento), *dream* (sueño) *design* (planes) y *destiny* (destino), siendo tratadas, en este estudio, las reuniones que correspondieron a las tres últimas fases. Diarios de campo fueron usados para el registro de las informaciones, además de la grabación de las declaraciones en audios. Se realizó el Análisis Temático de Contenido. **Resultados:** surgieron tres categorías: Organización del trabajo en equipo; Calificación de los procesos de trabajo; Desarrollo de acciones de educación en salud. Fueron planeadas acciones que contribuyen para prácticas volcadas a la Prevención Cuaternaria, como acciones de educación permanente, escucha calificada, garantía del acceso, trabajo colaborativo y reconocimiento del territorio. **Conclusión:** se promovió el diálogo y reflexiones sobre las prácticas e intervenciones desnecesarias/inapropiadas, realizadas en los servicios, así como sus riesgos, incorporando un plan de acción en esta dirección. **Descritores:** Atención Primaria a la Salud; Prevención Cuaternaria; Medicina Social; Medicalización; Sistema Único de Salud.

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INTRODUCTION

The provision of Primary Health Care (PHC) services proposes an organization and rationalization of available resources through basic care, with emphasis on disease prevention and health promotion measures⁽¹⁾. This configuration starts from the assumption that the professionals who work at this point of the Health Care Network need to review their practices, sometimes anchored in excessive clinical intervention and medicalization, in search of prevention⁽¹⁾.

In the practice of the teams, especially the Family Health teams (FHT), it is common to have an excess of preventive and diagnostic measures, which drive interventionist attitudes and which can imply even more demands on health services. These attitudes are influenced by the marketing of the pharmaceutical and biomedical industry, which lead to the excessive search for a long life, without illness, sacrifices and/or responsibilities, causing dependence on professional care⁽²⁾.

It is noteworthy that certain sufferings caused by situations inherent to life such as insomnia, bereavement, delivery, among others, do not always require some type of intervention involving medicalization and/or examinations. In these cases, the observation of precautionary principles and the assessment of the balance between harms-benefits can reduce unnecessary measures, which can become harmful to the health of the assisted individual⁽³⁾.

Quaternary Prevention (P4) is the fourth level of prevention and is considered non-linear, unlike the other levels (primary, secondary and tertiary)⁽⁴⁾, as it can be applied at all times of health care⁽⁵⁾. For this reason, the fact that it is not a frequent topic on the agendas of professionals in PHC is worrying. Thus, it is worth highlighting the importance of the performance of all professionals, in order to mitigate the culture directed to exclusive medical care and focused on the disease, reinforcing the competence and attribution of each professional in teamwork, including that of the nurses. In this sense, it is important to highlight the role of nurses in the FHT, as professionals who stand out for their leadership, being a strong influencer of the others.

The concept of P4 draws attention to the recognition that prevention practices and the constant search for health and longevity can often bring more harm than good to users and society. Screening programs and guidelines are applied indiscriminately, mainly in the healthy and asymptomatic population, with imprecise

dispensing of financial resources and health personnel. In turn, PHC professionals, responsible for welcoming and acting on the demands of users, need to know and act ethically in the face of pressure and the influences of the incessant search for interventionist health care⁽⁶⁾.

Based on the experience as a nurse, coordinator of an FHS, it is clear that there is a deficit in understanding about P4, as well as about the role of the team in this direction. A recent study, carried out in a municipality in the same region, showed that health professionals, although they recognize the concept of P4, need to be involved in this practice, involving managers and incorporating less aggressive alternatives to the treatment of users, such as Complementary Integrative Practices (CIP)⁽⁷⁾. From such reflections, the question is: what actions of an FHT can contribute to the practice of Quaternary Prevention?

Thus, the present study aimed to reflect with the team and develop an action plan that contribute to the practice of Quaternary Prevention in Primary Health Care.

METHOD

Participatory study with a qualitative approach based on Appreciative Inquiry (AI). Appreciative Inquiry originated in the areas of administration and management and consists of four phases, called the "4D cycle": discovery, dream, design, and destiny. It aims to instigate the performance and practices of the research participants, to qualify the dialogue, to share objectives, and to enhance what is best, generating positive attitudes⁽⁸⁾.

The study was conducted in a city in the Far West of the state of Santa Catarina and included the participation of nine professionals from a FHT, Oral Health Team (OHT) and Extended Core of Family Health and Primary Care (Nasf-AB). All participants were college graduates and had been working in the team for over two years: one physician, one nurse, one dentist, two psychologists, two physical therapists, one nutritionist, and one pharmacist. Professionals who, for some reason, were away from their functions during the data collection period were excluded.

The research was carried out in five educational meetings, which took place in the year 2020, lasting approximately one hour and fifteen minutes. The meetings were held at the Municipal Health Secretariat. The first and second meetings

corresponded to the discovery phase, the third to the dream phase, and the fourth and fifth meetings to the design and destiny phases, respectively.

In this article, we will analyze and discuss the results of the last three meetings, which in the AI represented the dream, design and destiny stages, whose dialogues and actions correspond to the objective of this article. These stages enable the construction and transformation of the lived reality, through problems pointed out as opportunities to improve the practices, building collective goals to be implemented, according to the team's possibilities⁽⁸⁾.

In the "dream" phase, the participants collectively built possibilities for the future, seeking to improve the scenario of actions aimed at the P4 in the team's daily routine⁽⁸⁾. After a warm-up dynamic, which allowed the team to identify and visualize the importance of collaborative work, the reflective activity proposed in the previous meeting and carried out at home by the participants was resumed. The reflective activity enables reflection on the object of study and corroborates the strategy to prepare for the next meeting⁽⁸⁾. In the sequence, two triggering questions were introduced, aiming to help and guide the dream phase: 1. what can be changed in the service provided by the team that favors actions focused on P4? 2. what P4 actions could be implemented in the reality of the service? The participants were asked to imagine and describe the best scenario, that is, the future actions to be implemented with a view to P4 actions in the municipality.

In the design phase, the participants carried out the planning of actions to make the dreams come true. Using the challenging goals identified by the group, it was possible to plan actions and strategies aiming at positive results for the future. The design considers the reality and the availability of resources⁽⁸⁾. By assessing what they would change and what they would keep in the organization of teamwork to achieve the dreams proposed in the previous meeting, the participants identified the actions/attitudes that the team needs to develop to achieve the dreams listed.

In the "destiny" phase, participants used intervention matrices to program strategies and define the performance of each team member. At this stage, the most challenging goals were outlined by the group, becoming motivators for the team to achieve positive results in the future⁽⁸⁾.

The recording of the meetings was carried out in a field diary, containing descriptive and

analytical notes, and the testimonies were also recorded in audio, after consent. These were later transcribed in full. Data processing was performed using Minayo's Content Analysis⁽⁹⁾. First, a pre-analysis of the raw material was carried out, by means of a floating reading of the transcripts of the speeches and the records in the field diary, in order to constitute the *corpus* of information. Then, the exploratory phase began, which resulted in the first codification, in order to reach the core of understanding the text. Finally, the text was cut into registration units. These units gave rise to the three main categories, which express actions that contribute to the planning of the practice of P4 by the team: "Organization of teamwork"; "Qualification of work processes in PHC"; "Development of health education actions."

The research was approved by the Research Ethics Committee, under number 3,375,951, of June 6, 2019, and was considered adequate to the requirements of Resolution 466/2012/CONEP/CNS/MS. The anonymity of the participants was preserved, through the use of letters that represent the initials of the professional category (Ph - physician, N - nurse, DS - dental surgeon, Psy - psychologist, Phy - physiotherapists, N - nutritionist, and Pha - pharmacist) and sequential numbers, due to the existence of more than one participant in the same category.

RESULTS

The team professionals identified that in order to plan practices aimed at P4 in PHC, there is a need, first, **to organize the teamwork**, in order to manage the team's work process in a collaborative way, facilitate communication with the sharing of information about the service flow and on users, recognize the epidemiological data of the territory. The difficulty encountered by the team to implement these practices is highlighted, both related to space, appropriate time or time spent by the team, as well as the structural dynamics of these meetings. These strategies would help to reduce unnecessary clinical interventions and possible harm to users, as expressed in the statements: "[...] first create space for these moments [...]" (N1). "[...] the reality is that my attitude is to attend to patients, I don't have a team attitude, and we don't hold meetings [...]" (Ph1). "[...] do not fragment care [...], discussion of STP [Singular Therapeutic Plans] [...]" (Phy2). "[...] screening of epidemiological data [...]" (DS1). "[...] I don't see any progress if there is not a fine line of

work between management and staff and even the population [...]” (N1).

Another possibility listed in the planning of practices aimed at P4 was the **qualification of work processes in PHC**, through PHE (Permanent Health Education), based on qualified listening and reception, time management and guaranteeing access to care in a timely manner, in care shared and in the decision shared with the users avoiding unnecessary or inappropriate referrals and practices. “[...] adequate time for consultation to improve listening [organization of the agenda] and qualified reception [...]” (Psy1). “[...] you have to fill out papers, make prescriptions, anamnesis, physical examination [...] the time is very short [...]” (Phy1). “[...] organize the agenda and the reception” (DS1). “[...] qualified listening, listening to the patient before requesting tests [...]” (N1). “[...] organizing this time, avoids unnecessary referrals [...]” (Pha1).

The development of **health education actions**, in the minds of the professionals was perceived as another possibility to plan practices aimed at P4 among the team. Professionals point

out: the importance of qualifying information about P4 for the population and creating health education devices for users, expanding pedagogical spaces to strengthen P4. Just as they envision that P4 needs the understanding and change of behavior and culture on the part of the population, and that a social media channel could facilitate this communication, even for health promotion. “[...] individual and collective studies on the exacerbated use of psychotropic drugs [...]” (Pha1). “[...] inform the population about the importance of P4 and what P4 is [...]” (Phy1). “[...] channel on social media for passing on health information, it is important for the population to also know about the risks [unnecessary interventions] [...]” (Phy1). “[...] using intersectoral spaces for health promotion [...]” (N1).

Based on the testimonies, on the intervention matrices and on the diary notes, resulting from the pedagogical movement carried out with the team, Box 1 presents the research results in a systematic way, illustrating the actions aimed at the practice of P4, according to the phases of the AI: dream, design and destiny.

Box 1. Matrix of Interventions aimed at the practice of P4, through the application of the dream, design and destiny phases of the Appreciative Inquiry - Santa Catarina, 2020.

Topic of Analysis	Dream	Design	Destiny		
Work process management	Promote and qualify teamwork	- The moments of the meetings must be thought out and organized by the team	- Define the themes of the meetings - Management participation		
		- Make it a moment to exchange ideas and experiences	- Weekly space for case discussion		
		- Survey of epidemiological data	- Actions aimed at the real needs of the population and the team		
		- Timely access guarantee	- Organization of the Agenda		
			- Establish an agenda, optimizing time and without fragmenting care		
			- Alternative means of scheduling: WhatsApp, CHA		
			- Training for all professionals for qualified listening and reception		
		- Shared service	Develop and use STP - Care plans aimed at reducing clinical and drug interventions		
		Health education actions	Promote education for behavior and culture change	- Individual and collective activities	- Social activities of primary prevention - Creation of multidisciplinary support groups - Groups using alternative therapies
				- Guide leaders from communities and other sectors and make them engage	- Build links with other management sectors - Informational videos in the waiting room
	- Use intersectoral spaces for health promotion				
	- Create a social media channel to pass on information about health, services and P4				
Permanent Education	- Moments of PHE			- Develop PHE Plan for the team	

Source: Prepared by the authors, 2021.

For each dream of the group, a plan was created, covering objectives for the destiny, in order to make the change possible, considering the reality and local resources. Through these data, the researcher elaborated infographics containing textual and visual content of the participants' propositions for the practice of P4 in PHC.

The other actions defined for design and destiny will later be worked on with the team, in meetings that will not be explored in this

manuscript. However, it is understood that, for the actions to be carried out, an effective design stage will be needed, and Strategic Design may be a good option for the team. At this point, internal and external obstacles and opportunities will be observed, as well as the time required for each proposed action, in addition to analyzing the feasibility of the plan, in its economic, political, organizational and cognitive dimensions, verifying

the availability of economic, administrative and political resources, necessary and/or available.

DISCUSSION

The study made it possible to plan actions that contribute to practices aimed at P4, such as the organization of teamwork, the development of internal communication channels, the qualification of work processes in PHC and the development of health education actions. From this perspective, professionals call attention to the importance of team meetings, which can be useful, including developing PHE movements, qualified listening; time management; access guarantee; collaborative work; shared decision and recognition of the territory. Such directions may help in understanding and changing the behavior of the team and, therefore, of the population, favoring P4. It is worth noting that most of the actions conceived in this collective are contained in public policies that guide the Unified Health System (SUS) and PHC, such as the National Policy on Primary Care (NPPC), the National Policy on Integrative Practices and Complementary, the National Policy for Permanent Education in Health (NPPEH), among others. This only reinforces the importance of the team revisiting prescriptions and permanently planning the best way to implement them, according to the local reality.

In PHC settings, planning practices aimed at the P4, in order to avoid or mitigate possible consequences of excesses resulting from unnecessary clinical interventions is a challenge, because it is a subject still permeated by doubts regarding the co-responsibility of professionals, users and service management, and even doubts about its acceptance. Moreover, the ideology of the guarantee of benefits offered by prevention generates a false expectation that certain preventive pharmacological treatments of risk factors guarantee longevity, causing a false security to users⁽¹⁾.

With the objective of provoking changes in care practice, training emerges as an essential path based on collaborative practice, forged in the co-responsibility between professionals, users and managers. In this way, the organization of the team and work relationships permeate the need for preparation and support from management, where collaboration between specialties, sharing of experiences and fulfillment of theoretical and practical tasks must consider the dimensions of

power, knowledge and care.⁽¹⁰⁾ In this direction, teamwork is essential for the development of P4 actions, removing the idea of professional corporatism on therapeutic decisions, in addition to involving the users in the decision process, thus improving the quality of the services provided, optimizing the chances of adherence to the care plan; plan that must be centered on the person, thus reducing interventionist practices⁽¹¹⁾.

Participants identified the need to change the team's attitude. The appreciation of collaborative work, efficient communication, the involvement of everyone in the design phase, were also notions that revealed the importance of a team that operates with the needs and demands identified in the reality of the service. Thus, they thought of actions aimed at reviewing their work process. Therefore, they found the importance of periodicity and participation of all professionals, in moments of PHE, team meetings and other sharing. It is worth noting that involving management is also essential when one wants to improve the services provided⁽¹²⁾.

Participants also recognized the importance of developing care based on the epidemiological data of the territory, in order to understand and act accurately on health conditions. The barriers listed by the respondents are often linked to the bureaucratization of information systems, allied to the deviations caused by the high demand for the service, making this type of action not widespread by the teams and making these data only of epidemiological importance, little discussed in team meetings or used in professional practice⁽¹³⁾.

The qualification of the professionals' work, in order to structure the care according to the service, is one of the aspects that should be part of the discussions and planning of the teams. The adequate time for care, with welcoming and qualified listening, emerges as a critical node in health services, because it is at the time of consultation that the individual exposes his or her complaints under the dialogue of the professional, in order to reach a diagnosis that sometimes triggers interventions dependent on tests and medications. In this sense, the time for the consultation should occur in a way that favors the shared decision between professional-user and the delay allowed, with the understanding that it will not be the first or last contact established between the parties and that other actions may be taken later⁽¹⁴⁾.

Thus, the time of consultation/care, which is considered the most favorable time for the

occurrence of excessive interventions, should occur in a way to favor and involve all professionals, but especially the prescribers, the moments of: "welcoming, listening, investigation, development of diagnostic interpretation, socialization of this interpretation, proposition, agreement and implementation of treatment"^(15:06). These movements favor P4's actions in defining a care plan where unnecessary or unjustifiable interventions do not occur. Attitudes like these also allow the effectiveness of P4 by enabling the action of all involved, in a scope of co-responsibility, knowledge and bond anchored in the ethical premise of "first do not do"⁽¹⁶⁾.

The qualification of work processes through PHE was recognized by the participants as a possible way to develop practices related to P4. The PHE meetings, even during systematized team meetings, favor the production of knowledge and the induction of collective and collaborative changes, with a view to organizing, learning and knowing the ways that allow the improvement of the services provided, among these the shared care, mainly in more complex cases where the risk of interventions and iatrogenic events is greater⁽¹⁷⁾.

It is necessary that PHC professionals recognize and assume responsibility for caring for a group of people over time, considering their territory of coverage, health and disease issues influenced by the environment. In this direction, qualified listening was considered fundamental by the participants. Linked to reception, it expands access and establishes a relationship of trust with the users, when it guarantees timely care. This was also a dream pursued by the team. Qualified listening aims to respect the users' autonomy in decision-making, sharing knowledge and providing P4 actions by reducing clinical interventions through medications and exams⁽¹⁸⁾.

The guarantee of access to care in a timely manner was considered important for the implementation of P4 practices, as it contributes to the construction of adequate care with the reduction of health inequities⁽¹⁹⁾. It is necessary to pay attention to creative approaches that expand the solvability of services, such as organizing the type of access and the agendas of professionals with adequate time, in a timely and longitudinal way, aiming to meet the particularities of acute and chronic situations, which demand different attitudes and time, mitigating the cascades of exams and medicalization⁽²⁰⁾.

Another important measure involves the reassessment of the access system in the PHC

services, especially in the Basic Health Units (BHU), aiming at better resolution, through reorganization of the dimensioning of registered users and professionals, as well as investing in professional qualification for the construction of a care plan appropriate to the unique context of each user. In PHC, chronic situations are recurrent, which require a protective posture from the professional, and acute situations that must be based on the allowed delay (monitor individuals with nonspecific symptoms and signs for a period, observe the evolution of the disease, without intervening) and anchored in self-care actions that favor therapy⁽¹⁴⁾.

The meaning of disease prevention present in the ideas of users and professionals, as a result of the biomedical culture, fed by the media, treating healthy people, contributes significantly to the increase in demand in health services and for invasive and interventionist clinical practice. Sometimes, the routines adopted in PHC are based on preventive care, based on protocols and guidelines that individualize prevention and fragment care; people who are really sick are not cared for, as is commonly identified when there is no room for acute situations in the agendas⁽⁶⁾.

It is necessary to invest in health education actions to inform the population of the services provided by the team and its organization, providing knowledge about P4 and other forms of prevention through current alternatives, such as the use of the media, which is increasingly present and determinant in health choices⁽²¹⁾. However, attention is also needed in relation to preventive actions that sometimes induce harm, not being acceptable or justifiable, as they can stimulate overmedicalization and overtreatment⁽⁶⁾. P4 is related to the part of social medicalization derived from clinical-sanitary care: the more P4, the less excessive medicalization, derived from professional and institutional action⁽¹⁾. In this way, the understanding is sought that some health situations do not require interventions, such as colds, insomnia, menopause, bereavement and delivery, as well as other common life problems that cause fear and, thus, demand professional and care interventions⁽³⁾.

It is up to professionals to recognize their role, acting in a committed way and with the ability to act in the face of uncertainties⁽²²⁾. That is why it is important to consider the bond, as P4 is dependent on an effective professional-user interaction. For PHC multiprofessional teams, guided by reflections and survey of actions diagnosed as favorable and that consider the

premise of “first not to do it” recommended by P4, it is recommended to use longitudinal monitoring and the delay allowed, based on the bond and the confidence. This must be established between professional-user and strongly contributes to the development of actions in this direction, protecting them from diagnostic and therapeutic interventionism applied indiscriminately in services today⁽¹⁴⁾.

FINAL CONSIDERATIONS

The research provided an opportunity to reflect and develop with the team a plan of actions that contribute to the practice of P4 in PHC. The importance of avoiding unnecessary practices and interventions carried out in the services was recognized, with a view to encouraging investment in actions that identify the needs of the enrolled population, mitigating the interventionist posture of professionals, as these not only expose users to damage but also cause a demand that is difficult to meet. It is necessary to consider, however, that the popularization of preventive measures in excess is accepted by the population as a favorable good.

Thus, even though P4 is focused on the professional attitude, especially the physician, the professional nurses, with their managerial and prescribing capacity of care, have fundamental role in the articulation of the team and in health education and must contribute to the effectiveness of this level of prevention. Furthermore, the involvement of the manager and the population is considered important, as they need to recognize the risks of abusive interventions and opt for treatment alternatives. The construction of spaces for action and reflection on the practice, making all the professionals involved responsible, is fundamental for the construction and evolution of the team, in this perspective.

As a limitation of the study, the context of this study was the reality of one single municipality, and the possibility of including other actors in new studies. Still, we emphasize again that, after this pedagogical moment, there will be other meetings for the planning of the team regarding each "destiny" and, in this sense, it will be necessary to analyze the feasibility of the plan, economically, politically and organizationally, paying attention to the resources available.

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