

NUTRITION AND PHYSICAL ACTIVITY COUNSELING: PRACTICE AND ADHERENCE OF PRIMARY CARE USERS

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ABSTRACT

The present study aimed to investigate counseling content provided by healthcare professionals for primary healthcare users, as well as users' difficulties in adhering to the counseling, through a cross-sectional study design. Interviews were conducted with 499 users at a primary healthcare unit, and 59.3% of them said that counseling had been provided, especially by physicians (93.6%), and it was based on healthy nutrition and physical activity practice (48.9%). Counseling was more frequently to users with greater numbers of morbid conditions ($p=0.001$). The main factors that made adherence difficult for users were lack of time (27.5%) and the need to change habits (23%). It was identified that counseling is still at initial stage within primary care, and there is a need for healthcare professionals, especially the nurse of the family health team to be more proactive in this process, focusing mainly on health promotion.

Descriptors: Counseling. Health promotion. Primary health care.

RESUMO

O presente estudo objetivou verificar o conteúdo do aconselhamento de profissionais de saúde direcionado a usuários da atenção primária, assim como as dificuldades de adesão destes acerca do que foi orientado, por meio de delineamento transversal. Foram entrevistados 499 usuários de uma Unidade Básica de Saúde, sendo a prática do aconselhamento referido por 59,3% dos usuários, que a vincularam especialmente aos médicos (93,6%) e à prática de uma alimentação saudável associada à atividade física (48,9%). O aconselhamento foi mais frequente entre os usuários com maior número de morbidades ($p=0,001$) e apresentou como principais barreiras à sua adesão a falta de tempo (27,5%) e a necessidade de mudança de hábitos (23%). Identificou-se que o aconselhamento ainda é incipiente na atenção primária, tornando-se necessário que profissionais de saúde, especialmente o enfermeiro da Equipe de Saúde da Família, atuem mais nesse processo, tendo como foco preponderante a promoção da saúde.

Descritores: Aconselhamento. Promoção da saúde. Atenção primária à saúde.

Título: Aconselhamento sobre alimentação e atividade física: prática e adesão de usuários da atenção primária.

RESUMEN

Este estudio tuvo el objetivo de verificar el contenido del asesoramiento de profesionales de la salud dirigidas a los usuarios de la atención primaria, así como las dificultades de su adhesión, de los mismos acerca de lo que fue orientado, través del la delimitación transversal. Se entrevistó a 499 usuarios de una Unidad Básica de Salud, la práctica del consejo referido por el 59,3% de los usuarios, que la vincularon especialmente a los médicos (93,6%) y a la práctica de una alimentación saludable asociada a la actividad física (48,9%). El consejo fue más frecuente entre los usuarios con un mayor número de morbididades ($p=0,001$) y presentó como principales barreras a su adhesión la falta de tiempo (27,5%) y necesidad de cambio de hábitos (23%). Se identificó que el consejo todavía es incipiente en la atención primaria, volviéndose necesario que profesionales de salud, especialmente el enfermero del Equipo de Salud de la Familia, actúen más en ese proceso, teniendo como enfoque preponderante la promoción de la salud.

Descriptores: Consejo. Promoción de la salud. Atención primaria a la salud.

Título: Asesoramiento sobre la dieta y la actividad física: prácticas y cumplimiento de los usuarios de la Atención Primaria.

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INTRODUCTION

In recent decades, due to rapid urbanization and industrialization, changes in the morbimortality profile of the Brazilian population were observed, being possible to verify not only a decrease in the prevalence of infect-contagious and parasitic diseases as well as the increase of non-communicable diseases (NCD) such as hypertension, diabetes and obesity⁽¹⁾. These diseases cause serious health complications, which interferes in quality of life and health of the person, resulting in higher costs for the government and society⁽²⁻³⁾.

In this regard, the need to work with issues related to the prevention and control of complications associated with NCD and promotion of healthy lifestyles is denoted, such as practice of regular physical activities and healthy nutrition through various methods, highlighting counseling⁽⁴⁾.

Counseling is an educational practice offered by health professionals in order to make patients active subjects of their health process. It is conducted considering respect of the individual autonomy and valuing their potential, making possible behavior changes and consequently improvement of their quality of life^(3,5,6).

Despite its potential, counseling is still infrequent in health services reality, it is more commonly performed to individuals with DCN⁽⁴⁾. Regarding the content of the recommendations, the encouragement for regular physical activity practice and healthy nutrition habits are common⁽⁴⁾. Thus, it was found that 29.4% and 34.4% of health services physicians in southern and northeastern Brazil, respectively, recommended to their patients the practice of physical activities⁽⁷⁾. The advice for healthy nutrition practices, indeed, was referred by 34.6% of diabetic users followed in primary care in Ribeirão Preto, São Paulo⁽⁸⁾.

As important as the practice of counseling on healthy lifestyle by professionals is the adherence of individuals. Thus, added to the challenge of conducting counseling, there are factors that make difficult the adherence of users of health services. Users nonadherence to health professionals recommended care has been reported as a major barrier to the effectiveness of actions⁽⁹⁾.

In this regard, it is estimated an adherence average below 50% in long-term therapy for DCN in developing countries⁽¹⁰⁾. Factors associated with

adherence may be: demographic, psychological, social and arising from the relationship between patient and health professional, as well as those related to treatment or the health system. Thus, identifying the barriers self-reported by patients to adhere healthy living styles may be useful to support actions to improve their adherence and hence the individuals quality of life⁽¹¹⁾.

In this context, the present study aimed to verify the counseling contents of health professionals addressed to primary care users, as well as the difficulties of their adherence on what was oriented.

METHODOLOGY

This is an analytical, cross-sectional study, conducted with adults and elderly users (aged 18 years or more) belonging to the scope area of a Basic Health Unit (BHU) in Belo Horizonte, Minas Gerais. This BHU has four Family Health Teams (FHT) and it is inserted in a low urban quality of life region (UQLI = 0.407) and high social vulnerability index (SVI = 0.60)⁽¹²⁾.

The choice to investigate counseling for adults and the elderly is due to convenience of obtaining information plus the limitations of studying this practice in children age groups considering its particularities. Counseling performed for children normally intend to monitor routine of their development, breastfeeding and introduction of complementary nutrition. Moreover, it is highlighted the development of this study in a BHU, considering a greater demand for this type of service.

The study was developed from the insertion of the Labor Education Program (Health-LEP) in BHU. This program, instituted by the Ministries of Health and Education, aims to encourage training processes focusing at the qualification of Primary Health Care. In Belo Horizonte, the Health-LEP includes faculty members and students of undergraduate health care courses and professionals of primary health care service, who were trained to conduct this research.

Users were randomly invited to participate in the study, through an individual or collective approach by Health-LEP academics, at the reception or in the building attached to BHU, at the moment they were waiting for some service (reception, medical or nursing appointment, scheduled specialist consultation, pharmacy service or operative groups).

After research explanation, its objectives and signing a consent form, we applied a questionnaire, properly tested, composed of 114 multiple choice questions related to lifestyle and individuals health conditions. For elaboration of this instrument, we performed a pilot study with ten adults and elderly users of a BHU inserted in the same region of the study.

For this research, information from questionnaire was used, which included sociodemographic characteristics (gender, age and years of education), counseling on nutrition and/or physical activity, health and anthropometric data history (body mass index).

Regarding counseling, the participant was asked if he/she was oriented during an individual or collective health service activity developed at BHU about practice of healthy nutrition and/or physical activity. If so, we proceeded to identification of the professional category involved, as well as user adherence to orientations given, and the main difficulties encountered by him/her in cases of partial or non-adherence.

Health history was verified through medical diagnoses reported by users, such as diabetes, hypertension, heart disease, dyslipidemia, among others.

The Body Mass Index [BMI = weight (kg)/height (m)²] was obtained by measuring the height and weight of the participants at the time of the questionnaire application, as recommended by the technical literature⁽¹³⁾. Weight was measured with an anthropometric digital scale of the Marte[®] brand, model PP200, with a maximum capacity of 200 kg and sensitivity of 50 g. For height measurement, we used a stadiometer of the Alturaexata[®] brand; with a maximum capacity of 2.13m and 1 mm resolution. BMI classification was done differently for adults⁽¹⁴⁾ and elderly⁽¹⁵⁾. Considering the categories classification extension of BMI in adults, we proceeded with the recategorization as underweight, including levels of thinness I, II and III; eutrophic and overweight. For the last, the categories included were: overweight, obesity class I, II and III.

Data analysis was carried out using the Statistical Package for the Social Sciences, version 19.0, and it included descriptive and inferential statistics. Thus, we applied the Kolmogorov-Smirnov test to assess the distribution of variables, chi-square test to compare proportions and simple Student t test to compare means. We adopted a significance level of

5% ($p < 0.05$). The variables are presented as mean and standard deviation, for those who adhered to the normal distribution; median and confidence interval of 95% for the others.

It is noteworthy that there are differences in the number of subjects for some variables analyzed, since some questions were not answered or did not need to be answered in case of negatively answer questions in advance. In the case of professional category involved in counseling, for example, the answer was obtained only by those users who reported been counseled at some health care service, individual or collective, in BHU.

The study was approved by the Ethics and Research Committee of the Federal University of Minas Gerais (CAAE: 0037.0.410.000-09) and the Municipality of Belo Horizonte (Process 0037.0.410.203-09A) and it met the ethical recommendations of Resolution 196 of the National Health Council from October 10th 1996.

RESULTS

We interviewed 499 person, 82.8% females, mean age 51 ± 15.5 years, median per capita income of R\$ 400.00 (95% CI: 456.77 – 534.66) and 5 years (95% CI: 6.3-6.9) of study.

From total users, 36.7% referred having a disease, 27.1% two diseases and 10.2% three or more diseases. The prevalence of overweight was 60.5% among adults and 52.5% among the elderly. For eutrophic, the prevalence were 37.2% and 36.5% respectively.

Counseling was reported by 59.3% of users, which was mostly accomplished by physicians (93.9%). There was a predominance of encouragement for healthy nutrition associated with physical activity (48.9%) (Table 1). It is noteworthy that the practice of counseling was similar between genders and categories of nutritional status ($p > 0.05$). However, this was higher among users who reported three or more diseases (82.4% vs. 71.9% for users with 2 diseases; 59.0% with 1 disease, and 37.7% without morbidities, $p = 0.001$).

Among users who adhered to all the orientations, most (63.0%) were counseled about the practice of healthy nutrition and physical exercise ($p = 0.001$). However, among those who followed no orientation, 50.0% had as counseling content just the encouragement for a healthy nutrition (Table 2).

Table 1 – Counseling Primary Health Care Users, Belo Horizonte/MG, 2010.

Variables	N	%
Counseling	499	100.0
Yes	296	59.3
No	203	40.7
Category of health professionals counseling*	296	100.0
Physician	278	93.6
Nurse	21	7.1
Nurse Assistant	3	1.0
Community health agent	3	1.0
Dentist	0	0.0
Nutritionist FHSN	8	2.7
Nutrition intern	1	0.3
Counseling content	217	100.0
Healthy nutrition associated to physical activity	104	47.9
Only physical activity	69	31.8
Only healthy nutrition	44	20.3

FHSN: Family Health Support Nucleus. *User could answer more than one option
Source: research data

Table 2 – Adherence of Primary Health Care users, according to counseling content. Belo Horizonte/MG, 2010.

User Adherence	Counseling Content (%)			p-value
	HN	PA	HN + PA	
All orientations	11.0	26.0	63.0	0.001
All orientations with determined time	16.5	35.4	49.4	0.001
Only some orientations	40.5	32.4	27.1	0.001
No orientations	50.0	10.0	40.0	0.001

PA: Physical Activity, HN: Healthy Nutrition.
Source: research data

Among counseled users, 218 (78.7%) reported difficulty in adherence, which is mainly due to lack of time (27.5%) and resistance to changing habits (23.0%), Table 3.

DISCUSSION

This study showed insufficient practice of counseling by health professionals, although higher than the percentage compared to the literature, which is greater performed by physicians. More-

over, the main contents addressed in counseling were the practice of healthy nutrition associated with regular exercise and this was addressed to users with more comorbidities. We identified extensive users difficult in adhering to the orientations, mainly for lack of time and resistance to change, despite the level of adherence found been higher to the mean of other developing countries⁽¹⁰⁾.

There was a low practice of counseling by BHU professionals, demonstrating the importance of proper training to work in the field of health

Table 3 – Difficulties of health service users in primary care to adhere to counseling on healthy lifestyles. Belo Horizonte/MG, 2010.

Difficulties	N	%
Lack of time	60	27.5
Changing habits	50	23.0
Financial	15	7.0
Controlling food impulse	9	4.0
Does not consider important to health	4	1.8
Does not know	2	1.0
Others (Laziness, anxiety, tiredness, lack of motivation)	78	35.7
Total	218	100.0

Source: research data

education. In practice, what is seen is a professional practice based on the users responsibility for their own misfortune, corroborating the preventive model of health education, which is premised on the idea that individuals' lifestyles are the main causes for the lack of health. For this theory, unhealthy habits are taken as a result of misleading individual decisions⁽¹⁶⁾.

The need to train professionals in the 'new' public health, prepared to face the complexities of health promotion, to deviate from possible theoretical-ethical conflicts, to seek social change and work according to the principles of a holistic health approach is, therefore, an urgent need⁽¹⁶⁾. This new approach to health education called Radical Model seeks to achieve its objectives by working with groups and it aims to promoting health in its positive sense, ie health as a resource for a life lived with quality. To achieve this goal, four stages are required: a) encourage reflection on aspects of personal reality, b) stimulate the search and collective identification of the causes of this reality c) examination of the implications of this reality and d) development of an action plan to change it⁽¹⁶⁾.

Regarding professional categories involved in counseling, there was a greater involvement of physicians, according to users' reference, which corroborates other studies in the literature^(8,17). The biomedical culture may also have influenced the users perception in relation to counseling, given its dominance in the health sector. Thus, besides the health teams still operate according to traditional logic, focusing on therapeutic actions, also the user

population seek health services aiming at actions centered on biomedical model. It is revealed, therefore, that the involvement and co-responsibility of the population about their health often remain, in the desire plan, not being a practical experience in the services⁽¹⁸⁾.

This scenario is further confirmed by the higher counseling practice among users with more comorbidities, reinforcing that health education has been used with greater focus on control and treatment of morbidities than for prevention strategies. This finding is also supported by the literature⁽⁴⁾. This scenario may be modified in the coming years with the consolidation of Family Health Support Nucleus (FHSN), which include various professional categories and they guide, above all, the actions of health promotion⁽¹⁹⁾.

Moreover, we highlight the important role of nursing professional in the Family Health Program (FHP), which includes not only medically interventions, but also relates to factors involved in comprehensive care to the user (social, economic and cultural religious factors, among others). Thus, the nurse has a specific characteristic to identify nursing diagnoses, related to both functional aspects such as emotional, social and environmental⁽²⁰⁾. These diagnoses may contribute to the knowledge of the characteristics of people receiving nursing care and address assistance. So, these professionals are able to contribute to the user health promotion, which starts with preventive work in primary care⁽²⁰⁾.

Furthermore, the role of the coordination and integration nurse of the team provides the

incentive for other members to offer the user full assistance⁽²¹⁾, including counseling.

Although inadequate, the percentage of counseling verified in this study was superior to the literature of approximately 40% in various health services^(4,7). The higher percentage of counseling detected in this study is attributed to the fact that users sought health care at BHU, requiring therefore any health intervention. On the other hand, users covered in home visits, operative groups and other educational actions outside the BHU were not included in the study, which is a limitation of this research.

Considering the users' behavior before counseling, adherence observed in this study is higher than in other studies developed with patients with comorbidities^(21,22). This characteristic may explain the higher rate of adherence verified. Possibly the BHU users in the study had lower prevalence of inadequate lifestyle habits and minor difficulties to change these habits.

Despite this improved adherence, there were difficulties for users to adhere to the orientations, mainly because of lack of time and resistance to change. These results were also verified by other authors who pointed out: personal problems^(3,23), health limitations⁽³⁾, financial problems⁽²³⁾, the type of strategy used, lack of social and family support, as well as the negative treatment results⁽³⁾ may compromise the adhesion to the orientations.

A similar study investigated the main barriers to counseling adherence, being the practice of physical activity and the lack of resources (80.5%) the main difficulty checked. Considering the adoption of a healthy nutrition, the lack of motivation (80.3%) was reported by users as main problem⁽²⁴⁾.

It is also worth noting that most users followed the orientations proposed by health professionals for some time, but soon abandoned them. Whereas one of the main barriers reported by users is related to resistance to change, it is argued that the lack of support from health professionals might have contributed to this behaviour. It is believed that the provision of information about what is a healthy nutrition or what is to be physically active are not enough to change habits, especially if one considers that this information is widely linked in the media and are configured as common sense. Thus, it is essential to advise individuals considering their particularities of life and not just trying to reproduce pre-established information⁽²⁵⁾.

In this context, it is believed that the process health-disease goes through a linguistic and cultural construction. In this direction, body, health and disease only acquire certain meanings in the context of culture and language that are understood and lived. Thus, health education, as part of a broader process of education, is understood both as a major instance of construction and transmission of knowledge and practices related to the ways of each culture conceives living healthy lives and the health/disease process⁽²⁵⁾.

In contrast to the factors hindering adherence, we noted it was significantly higher among individuals who were counseled on healthy nutrition and physical activity, demonstrating the importance recognized by users on these parameters. Accordingly, a study conducted with adults and elderly (n = 4,200) of BHU in the southern and northeast of Brazil found that healthy nutrition and physical exercise were considered by users to be more important to maintain health⁽⁴⁾.

The present study had some limitations such as homogeneous sample in terms of gender and purchasing power, impairing differentiated analyses according to these parameters, besides only asking individuals waiting for care service at BHU, not contemplating users in other scenarios. Additionally, the cross-sectional study design limits the understanding of causality; highlighting the self-reported data collection for health history and counseling.

It is noteworthy, however, that despite these limitations the study yielded advances in the discussion on the practice and importance of counseling on nutrition and/or physical activity in the reality of Primary Health Care.

CONCLUSION

The practice of counseling on nutrition and physical activity were incipient in the BHU studied and denoted difficulties concerning both for healthcare professionals as for users of the service. Thus, the need for differentiated actions and greater emphasis on health promotion in the service to address to these two groups of people were verified. For professionals, one may use health education strategies to enhance counseling and comprehensiveness of care, as well as reinforce the importance of educational orientation and

integration with other health professionals. Users can be offered opportunities to practice health and mainly support by a multidisciplinary team. Professionals should seek to know users' life context, identifying their problems and working towards social change, seeking to adapt what is necessary to the particularities of each user, thereby avoiding standard practices for individuals inserted in different realities.

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Received: 03.07.2012
Approved: 30.11.2012