Revista Brasileira em Promoção da Saúde

e-ISSN:1806-1230

Original Article

DOI: 10.5020/18061230.2017.6693

PARTICIPATION OF PRIMARY HEALTH CARE USERS IN HEALTH PROMOTION PRACTICES

Participação de usuários da atenção primária em práticas de promoção da saúde

Participación de usuarios de la atención primaria en prácticas de promoción para la salud

Maria Andressa Gomes Barbosa
Aggeu Magalhães Institute/ Oswaldo Cruz Foundation (*Instituto Aggeu Magalhães/ Fundação Oswaldo Cruz - IAM/FIOCRUZ*) - Recife (PE) - Brazil

Nathália Paula de Souza
Federal University of Pernambuco (*Universidade Federal de Pernambuco - UFPE*) - Vitória de Santo Antão (PE) - Brazil

Silvana Gonçalves Brito de Arruda
Federal University of Pernambuco (*Universidade Federal de Pernambuco - UFPE*) - Vitória de Santo Antão (PE) - Brazil

Silvia Pereira da Silva de Carvalho Melo
Aggeu Magalhães Institute/ Oswaldo Cruz Foundation (*Instituto Aggeu Magalhães/ Fundação Oswaldo Cruz - IAM/FIOCRUZ*) - Recife (PE) - Brazil

ABSTRACT

Objective: To analyze the factors associated with the participation of primary health care users in health promotion practices. **Methods:** Descriptive and analytical cross-sectional study carried out in the municipality of Vitória de Santo Antão, Pernambuco, Brazil, in 2016 with 148 participants aged over 20 years enrolled in three Family Health Care Centers or in the Small Waist Project. Data were collected using a semi-structured questionnaire addressing sociodemographic data, clinical profile, eating habits, and knowledge about and participation in health promotion practices and activities. Association between variables was checked using Pearson's Chi-squared test with a significance level of $p<0.05$. **Results:** A total of 148 individuals participated in the study, 76.4% (n=113) of whom were interviewed in the Family Health Care Center and 23.6% (n=35) in the extension project. The mean age was 52.9 years. In addition, 93.2% (n=138) of the participants were women and 57.4% (n=85) had a household income of up to one minimum wage. Participation in health promotion groups/activities was directly proportional to increasing age (p=<0.001), presence of comorbidities (p=0.005), continuous use of medications (p=0.001) and knowledge about the existence of groups/activities (p=0.001). On the other hand, users' participation was lower among those who worked (p=0.049) and those who lived in households with greater number of people (p=0.001). **Conclusion:** The variables that were associated with participation in health promotion activities were age, presence of comorbidities, use of medications, knowledge about the existence of educational practices, work and number of people in the household.

Descriptors: Primary Health Care; Community Participation; Health Promotion.

RESUMO

Objetivo: *Analisar os fatores associados à participação de usuários da atenção primária em práticas de promoção da saúde.* ***Métodos:*** *Estudo transversal de caráter descritivo e analítico, realizado no município de Vitória de Santo Antão/Pernambuco, em 2016, com 148 participantes, acima de 20 anos, cadastrados em Unidades de Saúde da Família ou no projeto de Extensão Cintura Fina. A coleta de dados ocorreu através de questionário semiestruturado, no qual constavam dados sociodemográficos, perfil clínico, hábitos alimentares, além de conhecimento e participação em práticas e atividades de promoção da saúde. A associação entre as variáveis foi realizada através do teste qui-quadrado de Pearson, adotando o nível de significância p<0,05.* ***Resultados:*** *Dos 148 participantes, 76,4% (n=113) foram entrevistados nas Unidades de Saúde da Família e 23,6% (n=35) no projeto de extensão, e tinham média de idade de 52,9 anos. Além disso, 93,2% (n=138) eram do sexo feminino e 57,4% (n=85) possuíam renda familiar de até um salário mínimo. A participação em grupos/atividades de promoção da saúde foi diretamente proporcional ao aumento da idade (p=<0,001), presença de comorbidades (p=0,005), uso contínuo de medicamentos (p=0,001) e o conhecimento sobre a existência dos grupos/atividades (p=0,001). Por outro lado, a participação mostrou-se menor entre os que trabalhavam (p=0,049) e residiam em domicílios com maior número de pessoas (p=0,001).* ***Conclusão:*** *As variáveis que se mostraram associadas à participação em atividades de promoção da saúde foram idade, presença de comorbidades, uso de medicamentos, conhecimento sobre a existência de práticas educativas, trabalho e número de pessoas por domicílio.*

Descritores: *Atenção Primária à Saúde; Participação da Comunidade; Promoção da Saúde.*

Received on: *07/03/2017*
Revised on: *09/01/2017*
Accepted on: *09/29/2017*

RESUMEN

Objetivo: *Analizar los factores asociados con la participación de los usuarios de la atención primaria en las prácticas de promoción para la salud.* ***Métodos:*** *Estudio transversal de carácter descriptivo y analítico realizado en el municipio de Vitória de Santo Antão/Pernambuco en 2016 con 148 participantes con 20 años o más, registrados en las Unidades de Salud de la Familia o no en el proyecto de Extensión Cintura Fina. La recogida de datos se dio a través del cuestionario semiestructurado con los datos sociodemográficos, el perfil clínico, los hábitos alimentarios, además del conocimiento y participación en prácticas y actividades de promoción para la salud. Se realizó la asociación entre las variables a través de la prueba Chi-cuadrado de Pearson con el nivel de significación de p<0,05.* ***Resultados:*** *De los 148 participantes, el 76,4% (n=113) fueron entrevistados en las Unidades de Salud de la Familia y el 23,6% (n=35) en el proyecto de extensión con una media de edad de 52,9 años. Además, el 93,2% (n=138) eran del sexo femenino y el 57,4% (n=85) tenían la renta familiar de hasta un sueldo mínimo. La participación en grupos/actividades de promoción de la salud ha sido directamente proporcional al incremento de la edad (p=<0,001), la presencia de comorbilidades (p=0,005), al uso continuo de medicamentos (p=0,001) y el conocimiento de la existencia de grupos/actividades (p=0,001). En cambio, la participación se mostró menor en los que trabajaban (p=0,049) y vivían en domicilios con más personas (p=0,001).* ***Conclusión:*** *Las variables que se asociaron con la participación en actividades de promoción de la salud fueron la edad, la presencia de comorbilidades, el uso de medicamentos, el conocimiento de la existencia de prácticas educativas, el trabajo y el número de personas por domicilio.*

Descriptores: *Atención Primaria de Salud; Participación de la Comunidad; Promoción de la Salud.*

INTRODUCTION

In 1988, the Constitution of the Federative Republic of Brazil declared health as a universal right and duty of the State, consolidating the Unified Health System (*Sistema* Único *de Saúde – SUS*)[1]. Food was considered a social right, but only in 2010, after the approval of the Constitutional Amendment No. 64/2010[2].

In order to reorganize Primary Health Care and comply with the doctrinal principles of SUS, in 1994 the Ministry of Health proposed the Family Health Strategy (*Estratégia Saúde da Família – ESF*), which prioritizes continuous and comprehensive health promotion, protection and recovery actions taking into account population needs and establishing relationships between users and professionals[3].

The changes that have occurred in Brazil in recent decades have transformed the population's way of life and epidemiological profile[4]. Currently, the country presents a complex scenario, with the presence of chronic and communicable diseases of external causes[5]. Chronic diseases are the main cause of death in the Brazilian adult population[4].

There is a consensus on the fact that many pathologies included in the group of noncommunicable diseases (NCDs) have some modifiable risk factors, such as inadequate eating habits, physical inactivity and smoking[6]. These diseases have a strong impact on morbidity and mortality rates and on the quality of life of the population; in addition, they increase the possibility of premature death and have unfavorable economic effects for the whole society[7].

These diseases also entail high direct and indirect costs, both for the families and for the health system. Therefore, it is necessary to develop and implement effective public policies targeted at their prevention, control of risk factors, and the strengthening of health services through various actions, including health promotion actions[8].

Both professionals and users face difficulties related to the provision of guidelines on and the adherence to diet and physical activity; therefore, health promotion actions targeted at this public are needed[9].

The population's disinterest and poor exercise of citizenship and health actions focused on the biomedical model of care and the development of activities that are not well adapted to the reality of the community are some of the factors related to users' low adherence to health education actions[10]. Other aspects, such as availability of and access to health promotion services and healthy food in the territory, the duration of diseases, and the use of medications are factors that also interfere with users' adherence to healthy lifestyles[11].

Considering that several actors involved in the health process, including the user, should feel responsible for the process of protection and care, it is necessary to overcome fragmented actions that do not prioritize the interests and needs of the population[12]. Thus, strategies supported by efficient public policies and the effective participation of professionals in health promotion actions can provide individuals with better quality of life and autonomy[11] in addition to reducing financial expenses in the health sector and the overlap of actions, making public policies more effective and efficient[12]. Given that, the objective of the present study was to analyze the factors associated with the participation of primary health care users in health promotion practices.

METHODS

This is a quantitative descriptive and analytical cross-sectional study carried out between June and October 2016. Data collection took place in three Family Health Care Centers (*Unidades de Saúde da Família – USF*) located in the municipality of Vitória de Santo Antão, Pernambuco, Brazil, and in the Small Waist Project run by the Federal University of Pernambuco/ Vitória Academic Center (*Universidade Federal de Pernambuco/Centro Acadêmico de Vitória – UFPE/CAV*).

The municipality of Vitoria de Santo Antão is located in the Zona da Mata Sul in the state of Pernambuco, 55 km away from the capital Recife. It has an estimated population of 135,805 inhabitants. The municipality has 25 USF, 20 of which are located in urban areas and 5 are located in rural areas[13]. The present study took place in the USF of Redenção, Mário Bezerra and Jardim Ipiranga, all located in urban areas of the city.

The USF selected for the study offered physical activity once a week (health group), activities to promote healthy eating and cognitive stimulation in groups held fortnightly (nutrition group and cognitive stimulation group), and addressed various topics related to healthy living habits, health promotion and disease prevention in monthly groups (older people's group).

The aforementioned extension project is targeted at individuals from the Água Branca neighborhood and the Senior Citizen Association (*Associação de Idosos da Matriz*) of the municipality. It offers primary health care activities under the responsibility of the UFPE/CAV three times a week in each place. Activities include regular physical activity, educational activities to promote healthy eating, and physical and nutritional assessment on a quarterly basis.

The sample was initially composed of 150 participants, but two refused to participate; therefore, the final sample consisted of 148 participants. The convenience sample included individuals aged over 20 years attending the USF or the extension project at the moment of data collection. Pregnant women were excluded from the sample because eating behaviors and habits at this phase of life differ considerably from the others; therefore, the information provided could be characterized as research bias.

The USF were also selected because of their convenient accessibility. At the time the research took place, the NASF team consisted of a nutritionist, a social worker, a psychologist, an occupational therapist, two physical therapists and two residents (nutritionist and physical educator) who supported eight Family Health Care Centers.

Data were collected through interviews and a semi-structured questionnaire addressing socioeconomic and demographic data (gender, age, education and household income). The clinical profile of the users was determined through self-reported morbidity (systemic arterial hypertension, diabetes mellitus and cardiovascular diseases) and use of medications. There were specific questions aimed at identifying users' knowledge about and participation in health promotion practices (knowledge of the existence of groups/health promotion activities offered in the USF and participation in/adherence to this type of activity). There were also questions addressing individuals' eating habits (guidelines on healthy eating, which professional provided these guidelines, adherence to the guidelines received, and factors that influenced food choices). These questions were elaborated based on instruments used in other studies[11,14], which were adapted to the reality of the places where the present research took place.

Adherence to health promotion practices was classified according to the frequency of participation in the groups, considering the routine activities of each group. Adherence to the activities offered in the USF was considered when the participants attended monthly groups once a month, fortnightly groups every fifteen days, and weekly groups once a week. Regarding the activities of the extension project, adherence was considered when the participants reported a minimum frequency of participation once a week.

Food intake was assessed through the "How is your food intake?" Test proposed by the Ministry of Health in the pocket version of the first Dietary Guidelines for the Brazilian Population[6]. The questionnaire includes 18 questions with an specific score for each answer. At the end of the test, the scores obtained in each answer are summed. If the value is up to 28 points, the individual is classified as "You need to make your food intake and your life habits healthier!". Between 29 and 42 points, the individual is classified as someone who should "watch out for food intake and other habits like physical activity and consumption of liquids". When the value is above 43 points, the message is "Congratulations! You are on the way to a healthy lifestyle". All the questionnaires were administered individually.

Users' perceptions of the motivations and difficulties for participating in health promotion groups/activities were identified through the following questions: "What reason (s) motivates you to continue attending the groups?" and "What is the biggest difficulty in attending/participating frequently in group activities?". The answers to these questions were categorized[15].

The data were analyzed using the SPSS 20.0. Pearson's chi-squared test was used to check for associations between the variables with a significance level set at $p<0.05$. The dependent variable was the users' participation in health promotion groups/ activities.

Figure 1 depicts the theoretical model of the present study based on assumptions found in the literature regarding the possible determinants and their degree of relationship to the outcome. At the most distal level are the socioeconomic and demographic variables, which influence all the others. At the medial level are the clinical aspects. At the most proximal level are the knowledge about the existence of health promotion activities and eating habits (Figure 1).

The study was approved by the Research Ethics Committee of the Health Sciences Center of the Federal University of Pernambuco (Approval No. 1.599.787). All the participants provided their written free informed consent.

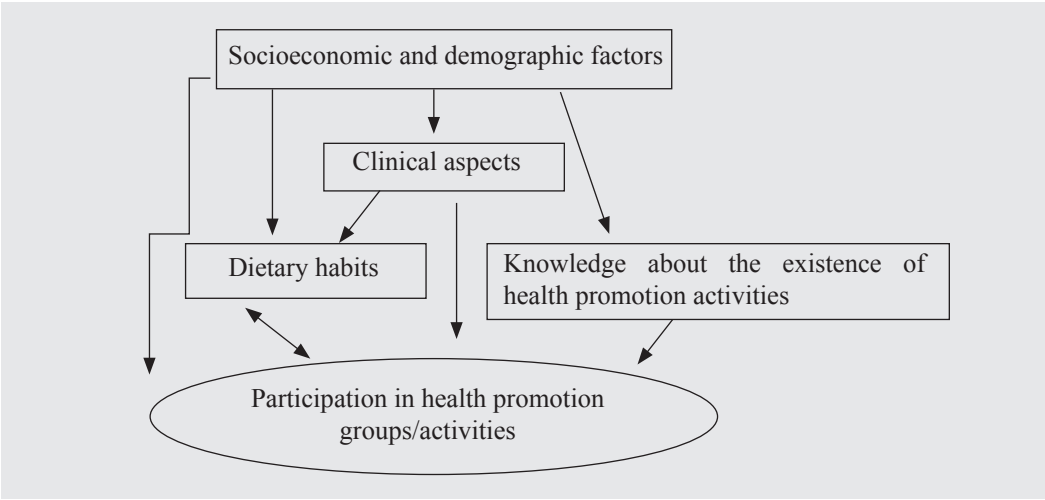

Figure 1 - Theoretical model of the potential determinants of users' participation in health promotion groups.

RESULTS

Of the 148 participants analyzed, 113 (76.4%) were interviewed in a USF and 35 (23.6%) were interviewed in the Small Waist project. The mean age of the participants was 52.9 years, with a minimum age of 21 years and a maximum of 86 years. There was a predominance of women (93.2%; n=138), age above 60 years (39.2%; n=58), up to 8 years of study (73.6%; n=109), household income of up to 1 minimum wage (57.4%; n=85), unemployed individuals (85.1%; n=126) (Table I).

Presence of comorbidities was reported by 68.2% (n=101) of the interviewees, with systemic arterial hypertension (SAH) (48.6%; n=72) and diabetes mellitus (DM) (9.5%; n=14) being the most commonly reported conditions (Table I).

Approximately 60% (n=86) of the users did not know about the existence of health promotion groups/activities in the USF they were attending. With regard to those who knew about these groups and activities (41.9%; n=62), most of them had been informed about their existence by USF professionals (45.1%, n=28). Adherence to health promotion groups/activities was found in 88.4% of the individuals (Table I).

Table I - Socioeconomic and demographic data, clinical profile, knowledge about and participation in health promotion groups/activities among users of the Unified Health System, Vitória de Santo Antão, Pernambuco, Brazil, 2016.

Variables	n (%)
Socioeconomic and demographic data:	
Gender	
Men	10 (6.8)
Women	138 (93.2)
Age	
21 to 39 years	36 (24.3)
40 to 59 years	54 (36.5)
60 years or older	58 (39.2)
Education	
Up to 8 years of study	109 (73.6)
More than 8 years of study	39 (26.4)
Monthly household income	
Up to 1 MW	85 (57.4)
More than 1 and less than 2 MW	48 (32.4)
More than 2 MW	15 (10.1)
Number of people living in the household	
Up to 2 people	61 (41.2)
More than 2 people	87 (58.7)
Curently employed	
Yes	22 (14.9)
No	126 (85.1)
Clinical aspects:	
Comorbidities	
Yes	101 (68.2)
No	47 (31.8)
Which comorbidities	
Diabetes *Mellitus*	
Yes	14 (9.5)
No	134 (90.5)
Systemic Arterial Hypertension	
Yes	72 (48.6)
No	76 (51.4)
Cardiovascular diseases	
Yes	10 (6.8)
No	138 (93.2)
Continuous use of medications	
Yes	96 (64.9)
No	52 (35.1)
Knowledge about and participation in health promotion practices:	
Knowledge about the existence of health promotion groups/activities	
Yes	62 (41.9)
No	86 (58.1)
How did you know about the existence of these groups/activities*	
USF professionals	28 (45.1)
Neighbor/friend/relative	15 (24.1)
Observed them when attending the USF	19 (30.6)
Do you participate in any health promotion group/activity?	
Yes	69 (46.6)
No	79 (53.4)
Where is the group/activity held?**	
USF	34 (49.2)
Extension Project (Small Waist)	35 (50.7)
Adherence to the group/activity in which you participate**	
Yes	61 (88.4)
No	8 (11.5)
Total	148 (100)

n: Absolute frequency; %: Relative frequency; MW: Minimum Wage; * n=62; ** n=69; USF: Unidades de Saúde da Família (Family Health Care Centers).

The interviewees' participation in health promotion groups/activities was directly proportional to the increase in age (p=0.001), the presence of comorbidities (p=0.005), the continuous use of medications (p=0.001), and the knowledge about the existence of groups/activities (p=0.001). On the other hand, participation was lower among those who worked (p=0.049) and lived in households with more people (p=0.001) (Table II).

Table II - Variables associated with the participation of users of the Unified Health System in health promotion groups/activities, Vitória de Santo Antão, Pernambuco, Brazil, 2016.

Variables		Participate n = 69	Do not participate n = 79	*p**
	n (%)	n (%)	n (%)	
Socioeconomic and demographic conditions:				
Gender				
Men	10 (6.8)	3 (4.34)	7 (8.86)	0.275
Women	138 (93.2)	66 (95.6)	72 (91.1)	
Age				
21 to 39 years	36 (24.3)	6 (8.69)	30 (37.9)	
40 to 59 years	54 (36.5)	21 (30.4)	33 (41.7)	<0.001
60 oyears or older	58 (39.2)	42 (60.8)	16 (20.2)	
Education				
Up to 8 years of study	109 (73.6)	52 (75.3)	57 (72.15)	0.658
More than 8 years of study	39 (26.4)	17 (24.6)	22 (27.8)	
Renda familiar mensal				
Up to 1 MW	85 (57.4)	34 (49.2)	51 (64.5)	
More than 1 and less than 2 MW	48 (32.4)	26 (37.6)	22 (27.8)	0.159
More than 2 MW	15 (10.1)	9 (13.04)	6 (7.59)	
Number of people living in the household				
Up to 2 people	61 (41.2)	38 (55.1)	23 (29.1)	0.001
More than 2 people	87 (58.7)	31 (44.9)	56 (70.9)	
Currently employed				
Yes	22 (14.9)	6 (8.69)	16 (20.2)	0.049
No	126 (85.1)	63 (91.3)	63 (79.7)	
Clinical aspects:				
Comorbidities				
Yes	101 (68.2)	55 (79.7)	46 (58.2)	0.005
No	47 (31.8)	14 (20.2)	33 (41.7)	
Diabetes Mellitus				
Yes	14 (9.5)	10 (14.4)	4 (5.06)	0.051
No	134 (90.5)	59 (85.5)	75 (94.9)	
SAH				
Yes	72 (48.6)	37 (53.6)	35 (44.3)	0.258
No	76 (51.4)	32 (46.3)	44 (55.6)	
CVD				
Yes	10 (6.8)	5 (7.2)	5 (6.32)	0.824
No	138 (93.2)	64 (92.7)	74 (93.6)	
Continuous use of medications				
Yes	96 (64.9)	54 (78.2)	42 (53.1)	0.001
No	52 (35.1)	15 (21.7)	37 (46.8)	
Users' knowledge:				
Knowledge about the existence of health promotion groups/activities in the USF where the user is served				
Yes	62 (41.9)	39 (56.5)	23 (29.1)	0.001
No	86 (58.1)	30 (43.4)	56 (70.8)	
Total	148 (100.0)	69 (100.0)	79 (100.0)	

n: Absolute frequency; %: Relative frequency; MW: Minimum Wage; SAH: Systemic Arterial Hypertension; CVD: cardiovascular disease; *Pearson's chi-squared test.

Regarding the variables related to dietary intake, the rates of receipt of guidelines on healthy eating (p=<0.001) and guidelines provided by nutritionists (p=0.001) were statistically higher among those participating in health promotion actions (Table III).

The assessment of dietary intake showed that 36 (24.3%) interviewees had healthy eating habits and lifestyle, and 30.4% (n=21) of those who participated in a health promotion group/activity presented such characteristics (Table III).

As for the participants' perception, the main reasons that encouraged them to attend the groups were: socialization (34.7%; n=24), health benefits (28.9%; n=20), learning new things (18.8%; n=13), and good teachers and methods used (10.1%; n=7). A few participants reported weight maintenance or loss (4.34%; n=3) and medical indication (2.89%; n=2).

The main difficulties in participating frequently in the activities/groups were: lack of time (25%; n=37), illness (6.1%; n=9), living far from the place where activities take place (6.1%; n=9), and lack of interest (6.1%; n=9).

Table III - Variables related to dietary intake and participation in health promotion practices among users of the Unified Health System, Vitória de Santo Antão, Pernambuco, Brazil, 2016.

Variables	n (%)	Participate n (%)	Do not participate n (%)	*p***
Received guidelines on healthy eating:				
Yes	95 (64.1)	64 (92.7)	31 (39.2)	<0.001
No	53 (35.8)	5 (7.2)	48 (60.7)	
Who provided the guidelines*				
ESF professionals	30 (31.6)	9 (14.1)	21 (67.8)	<0.001
Nutritionist	65 (68.4)	55 (85.9)	10 (32.2)	
With regard to the guidelines received, you:*				
Fully comply	20 (21.0)	10 (15.6)	10 (32.2)	
Partially comply	56 (58.9)	40 (62.5)	16 (51.6)	0.173
Does not comply at all	19 (20.0)	14 (21.8)	5 (16.1)	
Factors influencing food choices				
Price	64 (43.2)	26 (37.7)	38 (48.1)	
Regional habits	41 (27.7)	18 (26.1)	23 (29.1)	0.188
Other factors	43 (29.0)	25 (36.2)	18 (22.8)	
Do/would you like to receive food and nutrition guidelines?				
Yes	143 (96.6)	69 (100.0)	74 (93.6)	0.034
No	5 (3.3)	0 (0.0)	5 (6.32)	
"How is your food intake" test				
Watch out/Needs to make food intake healthier	112 (75.6)	48 (69.5)	64 (81.0)	
Congratulations	36 (24.3)	21 (30.4)	15 (18.9)	0.105
Total	148 (100.0)	69 (100.0)	79 (100.0)	

n: Absolute frequency; %: Relative frequency; * n= 95; **Pearson's chi-squared test; ESF professionals: (physician, nurse, CHW, dentist-surgeon)

DISCUSSION

The socioeconomic and demographic profiles of the population analyzed in the present study are in line with those reported in another study[16] that described the socioeconomic and demographic profiles of older people attending a primary health care center in Ceará, where the population was predominantly female (69.2%), had low levels of education (88.5%), was retired (69.2%), and had low monthly income (96.2%).

Finding that participation in the groups is directly proportional to age and inversely proportional to the number of people living in the same household in the present study shows how the socioeconomic and demographic contexts in which an individual is inserted can interfere with the participation in health promotion practices offered to the community, which should be taken into account in the development of such activities. In addition, another study[17] showed that more than half of the older people who participated in group educational activities were aged 60 to 70 years (51.4%) and had more morbidities than those who did not participate.

The presence of some comorbidity (68.2%) and the continuous use of medications (64.9%), which were reported by most of the interviewees in the present research, were also frequent in a study that sought to characterize older people attending senior groups and found that most of the participants had at least one disease (85.2%) and used at least one medication (88.5%)[18].

The prevalence of noncommunicable diseases among the comorbidities reported by the participants in the present study, such as SAH (48.6%) and DM (9.5%), constitutes a national public health problem. The prevalence of SAH among adults was 32% in 2010, affecting more than half of those aged 60-69 years and 75% of those over 70 years of age[19]. Self-reported diabetes in the population aged over 18 increased from 5.3% to 5.6% between 2006 and 2011[20]. In Recife, the frequency of adults who reported a diagnosis of SAH in the year 2014 was 28.4%, being one of the highest frequencies observed in Brazilian capitals. As for DM, this rate was 7.4%[21].

The lack of knowledge about health promotion groups/activities in USF and the role of USF professionals in the articulation of the user with the health service are important aspects that should be considered in the care process. This finding emphasizes the importance of a god relationship between the health professional and the user and the successful development of the activities performed in USF.

Users' access to health services, modifying the traditional way of entry, can be improved through the user embracement. User embracement facilitates the creation of relationships between the health team and the community. It should be noted that teamwork is accomplished through the articulation of actions and the interaction of health professionals[22]. The participation of community health workers in the coordination of health promotion groups is considered important to promote population's adherence to the activities, since these professionals live in the same territory and therefore know the user, the history of the community and the way they deal with relationships in life[23].

The inclusion of the nutritionist in the family health teams should also be considered as a positive strategy for a better compliance with the principles of healthy eating promotion. The specific knowledge held by this professional can help the development of strategies to meet the dietary and nutrition needs of a population taking into consideration their peculiarities[24]. In the present study, most of those who had received guidelines on healthy eating said the nutritionist was the professional directly responsible for the guidelines, especially among those who participated (85.9%) in health promotion groups/activities.

The nutritionist has stood out as a promoter of adequate and healthy eating habits in the primary health care service, with a key role in health promotion practices developed in the places where the research took place. The presence of this professional in primary health care services was established in 2005 through the Ordinance No. 380 of the Federal Nutrition Board[24]. Ordinance No. 154/08, which implements the NASF, prioritizes the work of these professionals according to the local needs[25].

In contrast, a study[26] carried out with 417 users of a primary health care service found that guidelines on healthy lifestyles was received by the minority of users (40.8%) and that physicians were responsible for most of these guidelines (87.6%), with the nutritionist being responsible for just 1.8% of the guidelines. The provision of these guidelines is of the utmost importance as it has a positive impact on the dietary pattern and, consequently, on the health and quality of life of the population[26]. In this regard, another study[27] concluded that the implementation of the NASF in large municipalities has been expanding the inclusion of the nutritionist in primary health care.

The guidelines on food and nutrition received were partially followed by a significant percentage of the participants (58.9%) in the present research. The main difficulties in following the guidelines reported by the participants were financial conditions and dietary restrictions. Another study showed that among those who adhered to the guidelines on healthy lifestyles, 50.9% followed all or some of the proposed guidelines and that the main barriers to adherence reported by non-adherents were the difficulty in changing habits (36.2%), the lack of time (25.4%) and financial difficulties (8.5%)[11].

Thus, the guidelines and the development of healthy eating promotion activities should consider the socioeconomic and cultural aspects of individuals and other particularities of the community or the individual. The health professional plays an important role in the empowerment of the user for a health promoting care, and only by knowing the user, the context, the potential and the adversities of the population they serve is that professionals will keep a relationship conducive to empowerment[28].

In this context, the ministerial agencies have developed materials to guide professionals in the development of actions to promote adequate and healthy eating in the context of primary health care, seeking to consider the integrality of the individual. An example of this is the New Dietary Guidelines for the Brazilian Population, which emphasizes the importance of the act of eating and seeks to encourage healthy eating habits through guidelines that must be observed day by day and that are easier to be adopted altogether, clarifying the dimension that involves the eating practices of the population[4].

In a study carried out in the Nova Colina UBS, located in the Federal District, the authors attempted to identify the learning methodology used in educational practices and the form of participation among users and concluded that the traditional model of education in health practices is still predominant. They emphasized that educational actions must be dialogic in order to be effective and have an impact[29].

With regard to dietary intake, it should be noted that most of the respondents in the present study who presented appropriate dietary intake participated in group activities. On the other hand, approximately 75% of the respondents had inadequate dietary intake and more than half of them did not participate in health promotion activities. These findings are in line with those

reported in a study[30] that sought to characterize habits and use of health services among hypertensive and/or diabetic users of a primary health care service; the study found that 76.0% of the interviewees presented inadequate/partially adequate dietary intake and low participation (5%) in hypertension and diabetes groups.

Despite the low participation in health promotion activities found among UBS users (30.1%), adherence was considered satisfactory since only 11.5% of the participants did not adhere to the activities. Low and satisfactory participation of older people in group educational activities and in leisure and physical activity actions have been reported[17,31]. Both studies were carried out in the state of Minas Gerais, the first in Uberaba and the second in Viçosa.

The analysis of the reasons for the non-adherence of a community to educational actions revealed that it is necessary to invest in the planning of creative strategies that recognize the local needs[9]. The same study showed that there is a possibility of better community adherence to actions provided that improvements are made in the dissemination and diversification of the discussion topics and in the number of meetings and the communication between professionals and users[9].

Health workers say that the population has difficulty joining the spaces and groups proposed since they are accustomed to social welfare measures[32]. Many SUS users still cannot set disease prevention and health promotion actions as reasons for seeking health care[33]. The reports show that the main reasons for seeking the health care center are: illness, medication or curative procedures[33].

The main difficulties in participating in group activities found in the present study were: lack of time, living away from the place where activities are held, not knowing about the existence of activities, and others. The same reasons were observed in two health care centers in Rio de Janeiro, where the interviewees were not involved in the group activities conducted by the Family Health Strategy teams. Some of the reasons reported were: lack of time, distance from the place, difficulty of access and lack of knowledge about the activities developed[34].

The lack of interest, the impossibility, and the appreciation of aspects related to curative care are also obstacles to users' participation in educational activities[10]. The need to do housework, take care of grandchildren so that their children can work, care for sick relatives, and unfavorable health conditions are also reasons that prevent the target audience from fully participating in leisure activities and physical activity[31].

As for the reasons that encourage participation in these activities, the main one, according to the participants in the present research, was socialization (34.7%). In another study[31], a similar opinion was observed. The interviewees reported socialization as a benefit resulting from the activities and the authors were able to conclude that the extension project in which the group participated was seen as a space for support, a place for exchanging experiences and strengthening social ties among users. Thus, creating spaces that lead to empowerment is an important means of promoting health care[31].

Knowledge of these factors is fundamental given the importance of health promotion practices in self-care and the consequent prevention of diseases and improvement of the quality of life of primary care users.

The sample size is a limitation of the present study as it limits the statistical analyses. Furthermore, the cross-sectional design also limits the analysis of associations between the associated variables and the outcome due to the impossibility of inferring a causal relationship.

CONCLUSION

The number of people living in the same household and the current employment status are inversely associated with participation in health promotion groups/activities. On the other hand, there is a directly proportional relationship between the outcome and sociodemographic aspects, such as older age, the presence of some comorbidity, the continuous use of medications, and knowledge of the existence of groups/activities. The possibility of socialization and the lack of time were mentioned as the main reasons that encourage and hinder, respectively, the participation in these activities.

CONFLICTS OF INTEREST

There were no conflicts of interest during the development of this research.

REFERENCES

1. Brasil. Constituição (1988). Constituição da República Federativa do Brasil. Brasília: Senado Federal; 1988.

2. Brasil. Emenda Constitucional n° 64 de 2010. Diário Oficial da União, Brasília, 05 fev. 2010 [accessed on 2016 Feb 10]. Available from: http://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc64.htm

3. Oliveira MAC, Pereira IC. Atributos essenciais da atenção Primária e a estratégia Saúde da família. Rev Bras Enferm [Internet]. 2013 [accessed on 2016 Feb 10]; 66(esp):158-64. Available from: http://www.scielo.br/pdf/reben/v66nspe/v66nspea20.pdf

4. Ministério da Saúde (BR). Guia alimentar para a população brasileira. 2ª ed. Brasília: Ministério da Saúde; 2014.

5. Miranda GMD. Saúde e desigualdade: o desafio brasileiro em um cenário de transição demográfica, epidemiológica e mudanças sociais [tese]. Recife: Centro de Pesquisas Aggeu Magalhães, Fundação Oswaldo Cruz; 2015.

6. Ministério da Saúde (BR). Guia alimentar para a população brasileira: promovendo a alimentação saudável. Brasília: Ministério da Saúde; 2008.

7. Ministério da Saúde (BR). Vigilância das doenças crônicas não transmissíveis [accessed on 2017 Mar 02]. Available from: http://portalsaude.saude.gov.br/index.php/o-ministerio/principal/leia-mais-o-ministerio/671-secretaria-svs/vigilancia-de-a-a-z/doencas-cronicas-nao-transmissiveis/14125-vigilancia-das-doencas-cronicas-nao-transmissiveis

8. Ministério da Saúde (BR), Departamento de Análise de Situação de Saúde. Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022. Brasília: Ministério da Saúde; 2011.

9. Santos RP, Horta PM, Souza CS, Santos CA, Oliveira HBS, Almeida, LMR, et al. Aconselhamento sobre alimentação e atividade física: prática e adesão de usuários da atenção primária. Rev Gaúch Enferm [Internet]. 2012 [accessed on 2016 Feb 12];33(4):14-21. Available from: http://www.scielo.br/pdf/rgenf/v33n4/02.pdf

10. Marin MJS, Moracvick MYAD, Rodrigues LCR, Santos SC, Santana FHS, Amorin DMR. Conhecendo os motivos da não adesão às ações educativas em saúde. Rev Min Enferm [Internet]**.** 2013 [accessed on 2016 Feb 16];17(3):500-4. Available from: http://www.reme.org.br/artigo/detalhes/668

11. Toledo MTT, Abreu MN, Lopes ACSL. Adesão a modos saudáveis de vida mediante aconselhamento por profissionais de saúde. Rev Saúde Pública [Internet]**.** 2013 [accessed on 2016 Feb 18];47(3):540-8. Available from: http://www.scielo.br/pdf/rsp/v47n3/0034-8910-rsp-47-03-0540.pdf

12. Ministério da Saúde (BR). Política nacional de promoção da saúde. Brasília: Ministério da Saúde; 2006.

13. Instituto Brasileiro de Geografia e Estatística - IBGE**.** Estimativas populacionais para os municípios e para as Unidades da Federação brasileiros em 01.07.2015 [accessed on 2016 Dec 15]. Available from: ftp://ftp.ibge.gov.br/Estimativas_de_Populacao/Estimativas_2015/estimativa_2015_TCU_20160712.pdf Accessed on Jan 2017

14. Andrade KA, Toledo MTT, Lopes MS, Carmo GES, Lopes ACS. Aconselhamento sobre modos saudáveis de vida na Atenção Primária e práticas alimentares dos usuários. Rev Esc Enferm USP [Internet]. 2012 [accessed on 2016 Mar 18];46(5):1117-24. Available from: http://www.scielo.br/pdf/reeusp/v46n5/12.pdf

15. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1977.

16. Clares JWB, Freitas MC, Almeida PC, Galiza FT, Queiroz TA. Perfil de idosos cadastrados numa unidade básica de saúde da família de Fortaleza-CE. Rev Rene [Internet]. 2011 [accessed on 2016 Oct 20];12(Nesp):988-94. Available from: http://www.revistarene.ufc.br/vol12n4_esp_pdf/a14v12esp_n4.pdf

17. Dias FA, Tavares DMS. Fatores associados à participação de idosos em atividades educativas grupais. Rev Gaúch Enferm [Internet]. 2013 [accessed on 2016 Oct 20];34(2):70-7. Available from: http://seer.ufrgs.br/index.php/RevistaGauchadeEnfermagem/article/view/22329/26040

18. Borges PLC, Bretas RP, Azevedo SF, Barbosa JMM. Perfil dos idosos frequentadores de grupos de convivência em Belo Horizonte, Minas Gerais, Brasil. Cad Saúde Pública [Internet]. 2008 [accessed on 2016 Oct 20]; 24(12):2798-808. Available from: http://www.scielo.br/pdf/csp/v24n12/08.pdf

19. Sociedade Brasileira de Cardiologia. VI Diretrizes Brasileiras de Hipertensão. Arq Bras Cardiol. São Paulo, 2010; 95(1 Supl 1):1-51.

20. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa. Vigitel-Brasil 2011: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico. Brasília: Ministério da Saúde; 2012.

21. Ministério da Saúde (BR). Vigitel Brasil 2014: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico. Brasília: Ministério da Saúde; 2015.

22. Pereira IC, Oliveira MAC. O trabalho do agente comunitário na promoção da saúde: revisão integrativa da literatura. Rev Bras Enferm [Internet]. 2013 [accessed on 2016 Nov 10];66(3):412-9. Available from: http://www.scielo.br/pdf/reben/v66n3/a17v66n3.pdf

23. Ministério da Saúde (BR). Política Nacional de Humanização. Brasília: Ministério da Saúde; 2010. (Cadernos HumanizaSUS. Atenção Básica, v. 2)

24. Conselho Federal de Nutricionistas (BR). Resolução CFN n° 380/2005 [accessed on 2017 Mar 1]. Available from: http://www.cfn.org.br/novosite/pdf/res/2005/res380.pdf

25. Ministério da Saúde (BR). Portaria GM nº 154, de 24 de janeiro de 2008 [accessed on 2017 Mar 1]. Available from: http://189.28.128.100/dab/docs/legislacao/portaria154_24_01_08.pdf

26. Andrade KA, Toledo MTT, Lopes MS, Carmo GES, Lopes ACS. Aconselhamento sobre modos saudáveis de vida na Atenção Primária e práticas alimentares dos usuários. Rev Esc Enferm USP [Internet]. 2012 [accessed on 2016 Nov 16];46(5):1117-24. Available from: http://revistas.usp.br/reeusp/article/view/48133/51950

27. Cervato-Mancuso AM, Tonacio LV, Silva ER, Vieira VL. A atuação do nutricionista na Atenção Básica à Saúde em um grande centro urbano. Ciênc Saúde Coletiva [Internet]. 2012 [accessed on 2016 Nov 16];17(12):3289-300. Available from: http://www.scielo.br/pdf/csc/v17n12/14.pdf

28. Taddeo PS, Gomes KWL, Caprara A, Gomes AMA, Oliveira GC, Moreira TMM. Acesso, prática educativa e empoderamento de pacientes com doenças crônicas. Ciênc Saúde Coletiva [Internet]. 2012 [accessed on 2016 Nov 20];17(11):2923-30. Available from: http://www.scielo.br/pdf/csc/v17n11/v17n11a08.pdf

29. Brito PP, Costa MP. Forma de participação dos usuários nas práticas educativas de uma equipe de saúde da família como meio de transformação. Rev APS [Internet]. 2015 [accessed on 2016 Nov 23];18(4):463-9. Available from: https://aps.ufjf.emnuvens.com.br/aps/article/view/2118/930

30. Bortoluz S, Lima LA, Nedel FB. Condições de saúde e utilização de um serviço de atenção primária em pacientes hipertensos e/ou diabéticos. Ciênc Saúde [Internet]. 2016 [accessed on 2016 Nov 28];9(3):156-66. Available from: http://revistaseletronicas.pucrs.br/ojs/index.php/faenfi/article/view/22009/15027

31. Alemida FLF, Gomes IS, Salgado SML, Freitas EL, Almeida RWS, Oliveira WC, et al. Promoção da saúde, qualidade de vida e envelhecimento: a experiência do projeto "Em Comum-Idade: uma proposta de ações integradas para a promoção da saúde de idosos das comunidades de Viçosa-MG". Rev ELO [Internet]. 2014 [accessed on 2016 Nov 28];3(2):71-80. Available from: http://www.elo.ufv.br/index.php/elo/article/view/52/50

32. Onocko-Campos RT, Campos GWS, Ferrer AL, Corrêa CRS, Madureira PR, Gama CAP, et al. Avaliação de estratégias inovadoras na organização da Atenção Primária à Saúde. Rev Saúde Pública [Internet]. 2012 [accessed on 2016 Nov 28];46(1):43-50. Available from: http://www.scielo.br/pdf/rsp/v46n1/2502.pdf

33. Franco ECD. A estratégia de saúde da família na perspectiva do usuário. Rev Enferm UFSM [Internet]. 2012 [accessed on 2016 Dec 01];2(1):49-58. Available from: https://periodicos.ufsm.br/reufsm/article/view/4002/3142

34. Teixeira C, Silva CCS, Bernardes GS, Sá NPP, Prado RS. O vínculo entre usuários e equipes em duas unidades de saúde da família em um município do estado do Rio de Janeiro. Rev APS [Internet]. 2013 [accessed on 2016 Dec 01];16(4):444-54. Available from: https://aps.ufjf.emnuvens.com.br/aps/article/viewFile/1725/768

Mailing address:
Maria Andressa Gomes Barbosa
Rua Francisco Bezerra das Neves, 54
Bairro: Abrigo
CEP: 55695-000 - Sairé - PE - Brasil
E-mail: andressa.gomes2009@hotmail.com