

Taís Rocha Figueira<sup>I</sup>  
Efigênia Ferreira e Ferreira<sup>II</sup>  
Virgínia Torres Schall<sup>III</sup>  
Celina Maria Modena<sup>III</sup>

# Women's perceptions and practices regarding prevention and health promotion in primary healthcare

---

## ABSTRACT

**OBJECTIVE:** To analyze the perceptions and participation of female basic health unit users with regard to prevention and health promotion.

**METHODOLOGICAL PROCEDURES:** Qualitative study with 20 users of a family health unit in the municipality of Belo Horizonte, Southeastern Brazil, in 2007. The interview script included questions about the health-disease process and prevention and health promotion. The content analysis technique was used to analyze the reports.

**RESULTS ANALYSIS:** The perception of disease prevention was influenced by Leavell & Clark's theory, which is expressed as actions that avoid the appearance, progression or worsening of disease. Health promotion was regarded as a level of prevention and associated with the individual responsibility and the positive concept of health. Prevention and health promotion practices were influenced by the positive health concept, the possibility of causing pleasure/displeasure, the way in which they might interfere in daily life, by the concept of will-power and the value attributed to life.

**CONCLUSIONS:** The discourse about disease prevention and health promotion is marked by traditional concepts. However, the inclusion of the positive health concept, allied to pleasure and will-power, are the main behavior determinants. Strategies based on a more comprehensive approach to the health-disease process are needed, thus reflecting the modern principles of health promotion.

**DESCRIPTORS:** Patient Education as Topic. Health Knowledge, Attitudes, Practice. Family Health Program. Health Promotion. Qualitative Research.

<sup>I</sup> Programa de Pós-Graduação em Ciências da Saúde. Centro de Pesquisas René Rachou. Fundação Oswaldo Cruz. Belo Horizonte, MG, Brasil

<sup>II</sup> Departamento de Odontologia Social e Preventiva. Faculdade de Odontologia. Universidade Federal de Minas Gerais. Belo Horizonte, MG, Brasil

<sup>III</sup> Laboratório de Educação em Saúde. Centro de Pesquisas René Rachou. Fundação Oswaldo Cruz. Belo Horizonte, MG, Brasil

### Correspondence:

Celina Maria Modena  
Av. Augusto de Lima, 1.715 – Barro Preto  
30190-002 Belo Horizonte, MG, Brasil  
E-mail: Celina@cpqrr.fiocruz.br

## INTRODUCTION

Disease prevention was defined by Leavell & Clark<sup>5</sup> (1976) as an “early action, based on knowledge of natural history in order to make the subsequent progress of the disease improbable”. Therefore, preventive intervention has the objective of avoiding the manifestation of specific ills (primary prevention), promoting a cure and limiting the damage (secondary prevention) and rehabilitating the individual (tertiary prevention).<sup>5</sup> Health promotion is one of the components of primary prevention, a set of measures for enhancing health and general well-being with a focus on the individual, their physical environment and lifestyle.<sup>2</sup> Health promotion programs based on this concept use the logic of individual rationality, in which the duly informed individual, given a number of action options, will be able to choose the one that will not cause him any harm or that will contribute to them achieving an optimal state of health.<sup>4</sup>

The meaning of health promotion has become broader and more comprehensive and has spread beyond characterizing the care level of preventive medicine. It comprises a set of strategies intrinsic to all actions and care levels,<sup>7</sup> leading to multisector and intersector intervention.<sup>2</sup> Thus, it is not a specific level of care; it is not found in any previous prevention actions; nor does it make individuals exclusively responsible for their own state of health and their behavior towards it.<sup>7</sup>

To expand and qualify disease prevention and health promotion actions in the services offered by the Brazilian National Health System and its management, the Ministry of Health has established organization guidelines and strategies through the National Primary Care Policy<sup>a</sup> and the National Health Promotion Policy<sup>b</sup>. The first proposes organization of primary care based on the Family Health Strategy, which promotes the reorientation of the biomedical model, valuing different knowledge and creating co-responsibilities that involve users, professionals and managers.

The National Health Promotion Policy<sup>b</sup> lays down a framework for health promotion, by proposing articulation between individual/collective, public/private, state/society, clinical/political and health sector/others sectors, in order to put together networks of commitment so that everyone participates in protecting and looking after their own life. The Policy recommends that health interventions should broaden their scope,

taking as their object health problems, needs, determinants and conditioners. Actions and services that work on the effects of falling ill and look beyond the health units and health system are considered. Consequently, focus is given on the living conditions and the expansion of healthy choices by individuals and communities in the places where they live and work.

Therefore, the objective of this study was to analyze perceptions and participation of female users of basic health units with regard to disease prevention and health promotion.

## METHODOLOGICAL PROCEDURES

A qualitative study, both exploratory and descriptive, was carried out with female users of a health center in the city of Belo Horizonte, Southeastern Brazil, between March and May 2007. This service attended a highly socially vulnerable population in terms of income, housing, infrastructure, education, work, access to health services, guaranteed food safety and social security.<sup>c</sup>

The inclusion criteria were: being of female sex, due to the greater responsibility that women have in questions of health within the family; being aged 18 or more; being a health center user and have accompanied the reorientation of the biomedical model through the Family Health Strategy. The women were contacted in the waiting room of the basic health unit and invited to take part in the study.

Semi-structured interviews<sup>8</sup> were conducted using a script with questions relating to the perception on the health-disease process, disease prevention and health promotion. The interviews were recorded and transcribed and had an average duration of 45 min. Data collection ended when saturation point was reached.<sup>9</sup>

To analyze the data the content analysis technique, as proposed by Bardin<sup>1</sup>, was used. Initially, the interviews were subject to a superficial reading to define the register and context units. Then, the analysis categories were defined to allow the register and context units that had common characteristics or that were inter-related to be grouped together. Finally, the data were interpreted, seeking to uncover what lay behind what was actually said.<sup>1</sup>

<sup>a</sup> Ministério da Saúde. Secretaria de Atenção Básica. Departamento de Atenção Básica. Política nacional de atenção básica. Brasília; 2006. [Série E. Legislação de Saúde. Série Pactos pela Saúde 2006, 4]

<sup>b</sup> Ministério da Saúde. Secretaria de Vigilância em Saúde. Política nacional de promoção da saúde. Brasília; 2006. (Série B. Textos Básicos de Saúde).

<sup>c</sup> Nahas MIP. Experience in the construction and perspectives of applicability of indices and indicators in the urban management of quality of life: a summary of the experience of Belo Horizonte (Minas Gerais, Brazil). Belo Horizonte: Belo Horizonte municipal administration; 2001 [cited on 10 March 2007]. Available at: <http://portalpbh.pbh.gov.br/pbh/ecp/contents.do?evento=conteudo&idConteudo=19630&chPlc=19630&termos=%20%20%20Nahas>

Twenty women were interviewed, of whom eight had finished high school and the other had completed (n=2) or interrupted (n=10) elementary education. The main occupations involved housework (n=13), followed by service provision (n=4) and working in sales (n=3). Age varied from 18 to 37 years, and the predominant age ranged from 25 to 30.

The analysis categories identified were: prevention concepts and measures; health promotion: the meeting of the old and new; factors that motivate or inhibit health promotion and disease prevention practices; the health center as a reference point for disease prevention.

The study was approved by the Research Ethics Committee of Belo Horizonte City Department of Health and conducted in line with the standards of the Helsinki Declaration.

## ANALYSIS AND DISCUSSION OF THE RESULTS

### Prevention concepts and measures

For the interviewees, prevention consisted in care procedures that avoid the appearance, progression or worsening of some disease or avoiding becoming pregnant. This concept of prevention shows traces of the natural history model of the disease, developed by Leavell & Clark<sup>5</sup> (1976), in which the preventive action takes place in two phases: the first, pre-pathogenic (health promotion and specific protection), in which the host, pathogenic agent and environment are in balance, and the second, pathogenic (diagnosis and early treatment, damage limitation and rehabilitation), when the disease is already present. At first, the reports do not focus on health promotion in the pre-pathogenic phase.

*“Prevention is being aware of things you can avoid before they happen, like dealing with this before and after. Back home we do everything to prevent dengue fever, but if it happens we already know the symptoms, what it is and the drugs you can't take.”* (E16)

In some reports the word prevention was synonymous with preventive gynecological examination. This interpretation may be due to the orthographic similarity between the words “prevention” and “preventive” and also because some users associate prevention with the use of medical technology and the gynecological examination represents their main reference point of a diagnostic examination carried out in the basic health unit.

*“I wanted to know what this is because my friends say: ‘I'm going to do prevention’.”*

*We only hear them say it, but as for knowing what it is - I don't know. My friend said that it's that thing with the uterus. I think they look at the uterus and clean it, just that.”* (E11)

The most frequently reported disease targeted for prevention was cervical cancer and the preventive measure recommended and adopted by most of the users consisted in having a gynecological examination for early diagnosis. The recurrence of mentions of cancer of the uterus may come from the fear they have, and which was noticeable in the reports, of developing a pathology that has tragic consequences, like imminent death, social discrimination and rejection and the loss of the ability to work.<sup>9</sup> Furthermore, the Pap smear is one of the main goals of the health policies directed at women and is in the guidelines of the Health Pact Consolidation<sup>a</sup> of the National Health System and the National Primary Care Policy.<sup>b</sup> This prioritization encourages educational campaigns and actively attracts women into the health centers to have a gynecological consultation, thus providing them with an experience with prevention and the assimilation of medical advice.

Despite the concern expressed by these women with regard to uterine cancer, their knowledge seemed restricted to the diagnostic examination; there were no reports about care being taken to avoid infection with the human papillomavirus (HPV), its main etiological agent.

*“I think that (prevention) is a disease in the cervix, it's cancer too. I'm more worried about this. Preventing it. That's why I always have to be looking, always coming to the doctor.”* (E3)

With the exception of AIDS, sexually transmitted diseases (STD) were mentioned in a general way. This suggests a gap in the knowledge of these women with regard to STDs, which are referred to as a group of diseases which they were unable to name. Thus, STD becomes something abstract and, therefore, conceived as a disease that “other people” have. The educational campaigns themselves reinforce this generalization when they are called STD/AIDS campaigns, but emphasize issues related to the latter. With regard to diseases transmitted via the blood, Deslandes et al<sup>4</sup> (2002) also found similar results, showing that those interviewed found it difficult to name other disease than AIDS.

The recommended measures for preventing sexually transmitted diseases reported by the interviewees were the use of condoms during sexual intercourse and having one sexual partner. In the study by Deslandes

<sup>a</sup> Ministério da Saúde. Secretaria de Atenção Básica. Departamento de Atenção Básica. Política nacional de atenção básica. Brasília; 2006. [Série E. Legislação de Saúde. Série Pactos pela Saúde 2006, 4]

<sup>b</sup> Ministério da Saúde. Secretaria de Vigilância em Saúde. Política nacional de promoção da saúde. Brasília; 2006. (Série B. Textos Básicos de Saúde).

et al<sup>4</sup> (2002), in addition to these precautions, the non-sharing of needles by drug-users was also mentioned. So daily experiences and the perception of being at risk to disease indicate what will be incorporated from scientific discourse. Condom was also indicated by the interviewees as a contraceptive method, like the pill and the intra-uterine device (IUD).

*“You must prevent from AIDS. You must use condom because AIDS is out there. Particularly these young girls who get pregnant and don’t want the baby and have an abortion.”* (E5)

Dengue fever was in the reports as a source of concern for some interviewees, who referred to cleaning the environment as a way of avoiding the disease.

*“Dengue. I’m dead scared of it. There where I work two people have already had it. It’s like they say, dengue’s in your own home or in your neighbor’s home. So we help by cleaning up the yard, we remove bottles, we don’t have such things just thrown around, garbage, things like that.”* (E16)

At the time of data collection, the community was taking part in an educational campaign about dengue, with the distribution of garbage bags and information about ways of preventing the disease, promoted by the basic health unit. However, dengue and ways of preventing it were less mentioned than pathologies, such as cervical cancer, STDs and measures related to health promotion. Chiaravalloti et al<sup>3</sup> (2002) and Lefèvre et al<sup>6</sup> (2004) noticed that the population had reached saturation point with regard to educational campaigns centered on passing on knowledge. They also emphasized that this type of practice trivializes prevention measures, makes it difficult for users to be receptive to educational messages and reduces the network of collaborators in the community.

### **Health promotion: a meeting of old and new concepts**

Health promotion came up in the reports when the interviewees were questioned about the preventive measures they knew about. Those most frequently mentioned, with the exception of the Pap smear, were related to strengthening health instead of fighting a particular disease. A balanced diet, doing physical exercise, avoiding tobacco and alcohol, being hygienic and enjoying leisure were mentioned by the interviewees, mainly as being important measures for promoting health and well-being.

The concept of health promotion as presented by the users had characteristics of the concept developed by Leavell & Clark<sup>5</sup> and also of the Ottawa Charter.<sup>2</sup> From the conservative perspective it brought the notion that health promotion represents a level of prevention and

that the individual is responsible for his/her own state of health and behavior. From a more modern approach, as defended in the Ottawa Charter, appears the positive view of health, which is identified with well-being and quality of life rather than the absence of disease. In this context, actions do not focus on reducing the risk of disease, but on gradually achieving better levels of health.<sup>2,7</sup>

*“So, I’m going to try and walk more. I’m not going to come to the health center by bus. I come on foot and I go home on foot to improve my health.”* (E1)

The difficulty with putting interventions that deal with the broader perspective of health promotion into operation, particularly as far as concerns the development of integrated and inter-sector actions, may have contributed to this mixture of old and new concepts that was found in the reports. Existing experiences are disperse, inarticulate and therefore, barely known.<sup>11</sup> Evaluation methodologies, which might facilitate their dissemination and incorporation by the services, are scarce.<sup>12</sup> As a consequence, the term “health promotion” is used inappropriately to refer to programs that have a preventive and individual focus. This inappropriate use means that disease prevention and health promotion start overlapping and the boundary between one and the other becomes imprecise.

The positive health concept and empathy with practices aimed at health, as shown by the users, indicate the development of new action strategies, the focus of which are on health and not disease. So, it is necessary to review, for example, holding disease-centered operative groups as part of the family health policy. This means a change in the discourse, emphasizing what can be done to increase well-being and not only to avoid the possibility that something might happen. While people outreach health, disease is characterized by responses of escape and reaction when the illness has already taken place and is recognized as a problem. This reactive way of dealing with disease creates difficulties for adherence to behavior that is preventive.<sup>6</sup>

*“[Interviewer] What would make you follow the doctor’s recommendation? One of these measures?”*

*“I think it’s wishing to be healthy and to continue being healthy.”* (E13)

*“I don’t even like to think about illness God spare me that.”* (E10)

### **Factors that motivate and inhibit health promotion and disease prevention practices**

Among the health promotion and disease prevention measures mentioned, it was possible to observe that people were concerned with trying to include them

in their daily routine. But this is not always possible, due to poor finances, lack of time, difficulty in getting help, the lack of a basic sanitation structure in the heavily populated community, a lack of collaboration on the part of neighbors when carrying out collective measures and the displeasure that adopting some of these measures causes.

*"It's difficult because we don't always have everything. We don't have in our home what they're telling us to eat. Whatever appears I eat."* (E13)

Despite the participants recognizing various obstacles to the adoption of health promotion and disease prevention measures, they are minimized because of their understanding that the deciding factor for taking care consists in their own will power and in the value they put on their own life.

*"If you've got will power. So, tell yourself, 'I'm going to avoid fat, salt and sweets'. Put into your head that you have to prevent disease to be healthy, not only for your body, but also for your mind and your mouth; it's easy to prevent disease."* (E1)

*"There are people who think that if they don't do this they're going to die anyway. So, I think it's more a case of the person's own ignorance"* (E10)

According to Oliveira & Valla<sup>10</sup> (2001), governments delegate to the population the responsibility for health promotion and disease prevention when they work with measures that are restricted to individual behavior. Consequently, individuals are made to feel guilty about their own state of health and the social, political and economic determinants and the responsibility of governments, policy makers and health professionals are not called into question.<sup>11</sup>

Faced with environments that are unfavorable to health, as is the case with the area covered by this particular health center, individual responsibility and blame arising from not managing to adopt the prescribed lifestyle are the origin of a feeling of weakness, of incapability, with a consequent reduction in self-esteem. If they feel devalued, people are unable to react to their problems and slip into passiveness, thereby determining a cycle of individual responsibility and the inability to change.

*"If you've got will power you can stop smoking too. I'm weak on this point; if there's any difficulty I get stressed. If I'm addicted to cigarettes, I get a cigarette, I smoke it and I relax."* (E6)

Some measures were considered easier to follow, depending on how long the person has had a particular habit and the loss that the new behavior might cause in her life, like interfering in the daily routine or a

loss of pleasure. Pleasure took center stage during the assessment of the possibility of adhering to a certain line of conduct. In general, for those participating in this study, pleasure and leisure are usually represented by the consumption of fatty food or sweets, cigarettes and alcohol, which are behaviors prohibited or highly regulated by health institutions.

*"For someone who has always had the habit, I think it's difficult. Now, for someone who doesn't have the habit I think it's easy to learn and do these things."* (E3)

*"You try with sweets, but you can't because they're very delicious."* (E18)

Therefore, it is necessary to exchange imposition by negotiation with and support for individuals, by showing them that carrying out certain actions may also generate pleasure and well-being and, above all, offer them new forms of leisure and pleasure, like the setting up of social, sports and culture centers.

### **Health centers as a reference point for disease prevention**

The health center was conceived as an environment aimed at solving some existing problem, except gynecological screening. It was considered to be a way of obtaining an early diagnosis, preventing sickness through vaccination and as a learning opportunity, whether by way of talks, posters or medical recommendations for better health.

*"My daughter sometimes gets sick, any little thing, and I take her to the health center. Even when I feel some pain I always come to the center. I bring my daughters to get them vaccinated."* (E17)

*"I follow all this business, these talks, everything that happens in the health center, like the talk before I put in my IUD"* (E15)

From what was said by the users, it was seen that reorientation of the care model is happening slowly, with health promotion and disease prevention actions being restricted to educational campaigns, influenced by the traditional approach of health education and to procedures considered a priority by the Ministry of Health, like vaccinations, the Pap smear and contraceptive methods.

### **CONCLUSIONS**

The discourse of the interviewees about disease prevention and health promotion was marked by the traditional concepts that are to be found in medical practice. However, the positive health concept has been incorporated and, along with the pleasure and will power factors, has acted as the main behavioral influence. Most of the time action has been focused on

health and well-being rather than on disease, which is the target of official discourse. This logic indicates the need for strategies that allow for broader approaches to the health-disease process, as a way of translating the current health promotion principles.

The reorientation of traditional practices requires investment in infrastructure, in human resources and in researches directed at promotion. These must identify interventions and develop assessment methodologies for checking their limits and potential.

## REFERENCES

1. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1979.
2. Buss PM. Promoção de saúde e qualidade de vida. *Cienc Saude Coletiva*. 2000;5(1):163-77. DOI:10.1590/S1413-81232000000100014
3. Chiaravalloti VB, Morais MS, Chiaravalloti Neto F, Fiorin AM, Barbosa AAC, Ferraz AA. Avaliação sobre a adesão às práticas preventivas do dengue: o caso de Catanduva, São Paulo, Brasil. *Cad Saude Publica*. 2002;18(5):1321-9. DOI:10.1590/S0102-311X2002000500025
4. Deslandes SF, Mendonça EA, Caiaffa WT, Doneda D. As concepções de risco e de prevenção segundo a ótica dos usuários de drogas injetáveis. *Cad Saude Publica*. 2002;18(1):141-51. DOI:10.1590/S0102-311X2002000100015
5. Leavell S, Clarck EG. Medicina Preventiva. São Paulo: McGraw-Hill; 1976.
6. Lefèvre F, Lefèvre AMC, Scandar SAS, Yassumaro S. Representações sociais sobre relações entre vasos de plantas e o vetor da dengue. *Rev Saude Publica*. 2004;38(3):405-14. DOI:10.1590/S0034-89102004000300011
7. Marcondes WB. A convergência de referências na promoção de saúde. *Saude Soc*. 2004;13(1):5-13. DOI:10.1590/S0104-12902004000100002
8. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec; 1999.
9. Oliveira MM, Pinto IC. Percepção das usuárias sobre as ações de prevenção do câncer do colo do útero na Estratégia saúde da Família em uma distrital de saúde do município de Ribeirão Preto, São Paulo, Brasil. *Rev Bras Saude Matern Infant*. 2007;7(1):31-8. DOI:10.1590/S1519-38292007000100004
10. Oliveira RM, Valla VV. As condições e as experiências de vida de grupos populares no Rio de Janeiro: repensando a mobilização popular no controle do dengue. *Cad Saude Publica*. 2001;17(Supl):77-88. DOI:10.1590/S0102-311X2001000700016
11. Sícoli JL, Nascimento PR. Promoção de saúde: concepções, princípios e operacionalização. *Interface (Botucatu)*. 2003;7(12):101-22. DOI:10.1590/S1414-32832003000100008
12. Souza EM, Grundy E. Promoção de saúde, epidemiologia social e capital social: inter-relações e perspectivas para a saúde pública. *Cad Saude Publica*. 2004;20(5):1354-60. DOI:10.1590/S0102-311X2004000500030