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Gamificação, uma nova forma de ensinar no ensino superior, *Millenium, 2*(18)

Editorial

GAMIFICAÇÃO, UMA NOVA FORMA DE ENSINAR NO ENSINO SUPERIOR

A gamificação consiste num novo método de ensino que faz uso da mecânica dos jogos e os leva para o campo educacional com a finalidade de obter melhores resultados.

A utilização do termo gamificação com o significado que conhecemos atualmente tem origem em 2008, sob a palavra "funware" cunhada por Gabe Zichermann.

Este conceito tem se tornado cada vez mais relevante em ambientes de ensino e aprendizagem, iniciando a ideia na indústria de mídia digital. O conceito vem se espalhando para outras áreas adaptando-se e sendo adotado em larga escala no segundo semestre de 2010.

A gamificação torna-se mais visível através de livros como Reality is Broken da autora Jane McGonigal e Game Based Marketing de Gabe Zichermann.

Em relação à concepção do conceito, apesar de haver muita controvérsia, a definição mais aceite é a de Sebastian Deterding, que conceitua que gamificação é o uso de elementos de design de jogos em contextos que não são jogos. Ressalta-se que isso visa levar a mudanças no comportamento e motivação dos usuários por meio de experiências que lembram os jogos. Outra questão que deve ser destacada entre as diferenças entre gamificação e o que são considerados jogos sérios é que são jogos planeados para que os jogadores se divirtam enquanto aprendem, treinam ou mudam o seu comportamento. A gamificação persegue o exposto acima, fazendo uso da mecânica e do design da experiência do jogo. Por isso, utiliza estratégias de jogo como recompensas, obtenção de pontos, classificação em níveis superiores, como pilar fundamental para que os participantes realizem as atividades solicitadas. Outra estratégia é também utilizar os desafios e tornar as pontuações visíveis para os restantes usuários, de modo que motive e desperte os participantes para que o seu envolvimento nas tarefas exigidas seja maior. Por fim, cabe destacar que a gamificação faz uso das redes sociais para aumentar o comprometimento e a interação entre os participantes.

Platão foi um dos primeiros a reconhecer a utilidade dos jogos, aconselhou que as crianças aprendam a contar usando maçãs e também que aqueles que possam se dedicar à construção brinquem com elementos que os ajudem a desenvolver habilidades relacionadas a elas.

Atualmente, encontramos diferentes teorias que consideram o jogo como um elemento importante na aprendizagem. Essas teorias valorizam o jogo de diferentes perspectivas. Assim, John Dewey (1997), entende o jogo como uma atividade inconsciente que auxilia o indivíduo a se desenvolver tanto mental quanto socialmente. Ele vê isso como uma atividade que prepara as crianças para se tornarem adultos trabalhadores saudáveis. Ele, portanto, entende o jogo como uma preparação.

Por outro lado, Montessori (1964), enfoca o jogo como elemento sensorial, de tal forma que faz uso de instrumentos de uso diário das crianças, como as mesas de areia. A criança aprende no seu próprio ritmo e o professor colabora para ajudá-la a aprender com o jogo. Nessa teoria, o brincar é entendido como um elemento de aprendizagem sensorial.

O jogo também é entendido como terapia, defendida a partir da teoria psicanalítica, que concebe o jogo como uma experiência de aprendizagem passível de repetição ou não, dependendo de se obter dele prazer ou não. Assim, a criança tenderá a repeti-la se tiver prazer e não se o resultado não for agradável (Freud, 1969).

Bruner (1960) teoriza que uma das principais funções do brincar na criança é realizar ações em cenários que simulam a vida real, enfatizando que o ambiente de brincadeira é seguro e livre de riscos. Assim, as crianças são preparadas para enfrentar momentos difíceis na vida real, para que, quando ocorrerem, sejam impedidas de sofrer estresse (Sutton-Smith et al., 1978). Ele, portanto, entende o jogo como um julgamento.

Piaget explica que a brincadeira infantil não é uma atividade sem sentido, mas muito pelo contrário, uma vez que possui uma dimensão plural e definida no seu próprio desenvolvimento. Essa teoria entende o jogo como desenvolvimento intelectual, além de considerar que é um comportamento inato que se insere e permanece por toda a vida, mesmo quando o indivíduo já é adulto (Piaget, 1999).

E, por fim, o jogo como desenvolvimento social. Vygotsky refere a-se ao jogo simbólico ao enfatizar que as crianças transformam alguns objetos e os transformam, com a sua imaginação, em outros que têm um significado diferente para eles. O jogo torna-se assim um espaço de relacionamento e interação social (Vygotsky, 1978).

O uso da gamificação nas salas de aula está a tornar-se cada vez mais difundido. A gamificação é usada em níveis educacionais não apenas para crianças, mas também em níveis primários e superiores, até mesmo na universidade. A gamificação permite uma série de vantagens que devem ser consideradas como elemento complementar ao ensino tradicional e magistral, ministrado por um professor especialista, que em nenhum caso pode ser substituído por este tipo de método. O ideal é combinar a educação tradicional com as estratégias de gamificação, de forma que uma maior probabilidade educacional seja alcançada. Também deve ficar claro que a gamificação deve ser desenvolvida em busca de um objetivo educacional previamente definido para motivar os alunos e direcioná-los para isso. É importante notar que se a gamificação não for bem feita, pode ser mais uma distração do que um método de ensino complementar.

Em resumo, uma série de benefícios emocionais, cognitivos e sociais são atribuídos à gamificação onde o desenvolvimento de relações sociais positivas e a promoção de um sentimento de integração são os principais benefícios sociais observados para a gamificação. A gamificação permite gerar aprendizagem significativa nos alunos, favorecendo a internalização de conteúdos, intensificando a sua motivação e envolvimento, fazendo uso dos sistemas pontuação-recompensa-objetivo dos jogos. Existem diferentes ferramentas que podem ser utilizadas em ambientes universitários que permitem criar exercícios, tarefas ou estabelecer recompensas e distintivos, além de acompanhar o trabalho diário dos alunos, de forma que eles avancem nas tarefas e exercícios testando os seus conhecimentos. Dessa forma, trabalha com o reforço, apoio e aprimoramento académico que ajuda a aumentar o interesse dos alunos pelo sua aprendizagem e facilita o acesso à tecnologia por parte dos professores. A maioria dessas ferramentas é baseada na aprendizagem baseada em problemas, que pode ser adaptada ao conteúdo em cada caso enquanto os alunos aprendem brincando.

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Editorial

GAMIFICATION, A NEW WAY OF TEACHING IN HIGHER EDUCATION

Gamification consists of a new teaching method that makes use of the mechanics of games and takes them to the educational field with the purpose of obtaining better results.

The use of the term gamification with the meaning that we currently know originates in 2008, under the word "funware" coined by Gabe Zichermann. This concept has become increasingly relevant in learning and teaching environments, starting the idea in the digital media industry. The concept has been spreading to other areas adapting and being adopted on a large scale in the second half of 2010.

Gamification becomes more visible through books like Reality is Broken by author Jane McGonigal and Game Based Marketing by Gabe Zichermann.

Regarding the conception of the concept, despite the fact that there has been much controversy, the most accepted definition is Sebastian Deterding, which conceptualizes that gamification is the use of game design elements in contexts that are not games. It should be noted that this aims to lead to changes in the behavior and motivation of users through experiences that are reminiscent of games. Another issue that should be highlighted between the differences between gamification and what are considered serious games is that they are games that are planned so that players are entertained while they learn, train or change their behavior. Gamification pursues the above by making use of the mechanics and design of the game experience. Therefore, it uses game strategies such as rewards, obtaining points, classification in higher levels, as a fundamental pillar for the participants to carry out the requested activities. Another strategy is also to use the challenges and make the scores visible to the rest of the users, so that it motivates and awakens the participants so that their involvement in the tasks required is greater. Finally, it should be noted that gamification makes use of social networks in order to increase commitment and interaction between participants.

Plato was one of the first to recognize the usefulness of games, he advised that children learn to count using apples and also that those who could dedicate themselves to building play with elements that help them develop skills related to construction.

Currently, we find different theories that consider the game as an important element in learning. These theories value the game from different perspectives. Thus, John Dewey (1997), understands the game as an unconscious activity that helps the individual to develop both mentally and socially. He sees it as an activity that prepares children to become healthy working adults. He therefore understands the game as preparation.

On the other hand, Montessori (1964), focuses on the game as a sensory element, in such a way that it makes use of instruments of daily use for children, such as sand tables. The child learns at his own pace and the teacher collaborates to help him learn from the game. In this theory, play is understood as an element of sensory learning.

The game is also understood as therapy, defended from psychoanalytic theory, which conceives the game as a learning experience that is subject to repeating it or not depending on whether or not pleasure is obtained from it. So the child will tend to repeat it if he gets pleasure and not if the result is not pleasant (Freud, 1969).

Bruner (1960) theorizes that one of the main functions of play in children is to carry out actions in scenarios that simulate real life, emphasizing that the environment in play is safe and risk-free. Thus, children are prepared to face difficult moments in real life, so that when they occur, they will be prevented from suffering stress (Sutton-Smith et al., 1978). He therefore understands the game as a trial.

Piaget explains that children's play is not a meaningless activity, but quite the opposite, given that it has a plural and defined dimension within its own development. This theory understands the game as intellectual development, in addition to considering that it is an innate behavior that is inserted and remains throughout life, even when the individual is already an adult (Piaget, 1999).

And, finally, the game as a social development. Vygotsky refers to symbolic play by emphasizing that children transform some objects and turn them, with their imagination, into others that have a different meaning for them. The game thus becomes a space for relationships and social interaction (Vygotsky, 1978).

The use of gamification in classrooms is becoming more and more widespread. Gamification is used at educational levels not only for children, but also at Primary and higher levels, even at university. Gamification allows a series of advantages that must be taken into account as a complementary element to traditional and masterful teaching, taught by an expert teacher, which in no case can be replaced by this type of method. The ideal is to combine traditional education with gamification strategies, in such a way that a higher educational probability is achieved. It must also be clear that gamification must be developed in pursuit of a previously defined educational objective to motivate students and direct them towards it. It is important to note that if gamification is not done well, it can be more of a distraction than a complementary teaching method.

In summary, a series of emotional, cognitive and social benefits are attributed to gamification where the development of positive social relationships and the promotion of a feeling of integration are the main social benefits observed for gamification. Gamification allows generating significant learning in students, favoring the internalization of content, intensifying their motivation and involvement, making use of the score-reward-objective systems of the games. There are different tools that can be used in university environments that allow you to create exercises, tasks or establish rewards and badges, as well as monitor the daily work of students, in such a way that they advance in the tasks and exercises by testing their knowledge. In this way, it works with the reinforcement, support and academic improvement that helps to increase the interest of students in their learning and facilitates access to technology by teachers. Most of these tools are based on problem-based learning, which can be adapted to the content in each case while students learn by playing.

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Editorial

GAMIFICACIÓN, UNA NUEVA FORMA DE ENSEÑANZA EN LA EDUCACIÓN SUPERIOR

La gamificación consiste en nuevo método de enseñanza que hace uso de la mecánica de los juegos y los lleva al ámbito educativo con el propósito de obtener mejores resultados.

El uso del término gamificación con el sentido que conocemos actualmente se origina en 2008, bajo la palabra “funware” acuñada por Gabe Zichermann.

Este concepto ha ido siendo cada más relevante en los entornos de aprendizaje y enseñanza, iniciándose la idea en la industria de los medios digitales. El concepto se ha ido extendiendo a otras áreas adaptándose y adoptándose a gran escala en la segunda mitad de 2010.

La gamificación consigue ser más visible mediante libros como Reality is Broken del autor Jane McGonigal y Marketing basado en juegos de Gabe Zichermann.

En cuanto a la concepción del término, a pesar de que ha existido mucha controversia, la definición más aceptada es la Sebastian Deterding, que conceptualiza que la gamificación es el uso de elementos de diseño de juegos en contextos que no son juegos. Cabe resaltar que ésta pretende dar lugar a cambios en el comportamiento y la motivación de los usuarios a través de experiencias que recuerdan a los juegos. Otra cuestión que se debe destacar entre las diferencias que existen entre la gamificación y los considerados juegos serios es que se trata de juegos que están planificados para que los jugadores se entretengan mientras aprenden, entrenan o cambian el comportamiento. La gamificación persigue lo anteriormente descrito haciendo uso de la mecánica y el diseño de la experiencia del juego. Utiliza, por tanto, estrategias de los juegos tales como las recompensas, obtención de puntos, clasificación en niveles superiores, como pilar fundamental para que los participantes realicen las actividades solicitadas. Otra estrategia es también la de utilizar los desafíos y hacer visibles las puntuaciones para el resto de usuarios, de modo que consigue motivar y despertar a los participantes para que su implicación en las tareas demandadas sea mayor. Por último, hay que destacar que, la gamificación hace uso de las redes sociales con la finalidad de incrementar el compromiso y la interacción entre los participantes.

Platón fue uno de los primeros en reconocer la utilidad de los juegos, aconsejaba que los niños aprendieran a contar haciendo uso de manzanas y también que aquellos que podrían dedicarse a construir jugaran con elementos que les ayudaran a desarrollar habilidades relacionadas con la construcción.

En la actualidad, encontramos distintas teorías que consideran el juego como un elemento importante en el aprendizaje. Estas teorías valoran el juego desde perspectivas diferentes. Así, John Dewey (1997), entiende el juego como una actividad inconsciente que ayuda al individuo a desarrollarse tanto mentalmente como socialmente. Considera que se trata de una actividad que prepara a los niños para convertirse en adultos trabajadores saludables. Entiende pues el juego como preparación.

Por otra parte, Montessori (1964), se centra en el juego como elemento sensorial, de tal manera que hace uso de instrumentos de uso cotidiano para los niños, como pueden ser las mesas de arena. El niño aprende a su propio ritmo y el docente colabora para ayudarle a aprender del juego. En esta teoría el juego se entiende como un elemento del aprendizaje sensorial.

También se entiende el juego como terapia, defendido desde la teoría psicoanalítica, que concibe el juego como una experiencia de aprendizaje que está sujeta a repetirla o no según se obtenga o no placer de ésta. De modo que el niño tenderá a repetirla si obtiene placer y no lo hará si el resultado no es placentero (Freud, 1969).

Bruner (1960) teoriza que una de las funciones principales del juego en los niños es la de llevar a cabo acciones en escenarios que simulan la vida real, destacando que en el juego el ambiente es seguro y está libre de riesgos. Así, los niños se preparan para afrontar momentos difíciles en la vida real, de manera que cuando se produzcan se evitará que sufran estrés (Sutton-Smith et al., 1978). Entiende pues el juego como ensayo.

Piaget explica que el juego de los niños no es una actividad sin sentido, sino todo lo contrario, dado que tiene una dimensión plural y definida dentro de su propio desarrollo. Esta teoría comprende el juego como desarrollo intelectual, además de considerar que se trata de una conducta innata que se inserta y permanece a través de toda la vida, incluso cuando ya el individuo es un adulto (Piaget, 1999).

Y, por último, el juego como desarrollo social. Vygotsky hace referencia al juego simbólico resaltando que los niños transforman algunos objetos y los convierten, con su imaginación, en otros que tienen para ellos un significado diferente. El juego se convierte de este modo en un espacio de relación e interacción social (Vygotsky, 1978).

El uso de la gamificación en las aulas está cada vez más extendido. La gamificación se utiliza en niveles educativos no sólo infantiles, sino también en Primaria y en niveles superiores, incluso en los universitarios. La gamificación permite una serie de ventajas que han de ser tenidas en cuenta como elemento complementario a la enseñanza tradicional y magistral, impartida por un profesor experto, que en ningún caso será sustituible por este tipo de método. Lo ideal es combinar la educación tradicional con estrategias de gamificación, de tal modo que se consiga alcanzar una probabilidad educativa superior. Se ha de tener claro además que la gamificación debe estar desarrollada persiguiendo un objetivo educativo previamente definido para motivar al alumnado y dirigirlo hacia el mismo. Es importante destacar que en el caso de que la gamificación no se realice bien puede ser más un distractor que un método de enseñanza complementario.

En resumen, se atribuye a la gamificación una serie de beneficios emocionales, cognitivos y sociales donde el desarrollo de relaciones sociales positivas y la promoción de un sentimiento de integración son los principales beneficios sociales observados para la ludificación. La gamificación permite generar un aprendizaje significativo en los estudiantes, favoreciendo la interiorización de contenidos, intensificando su motivación e implicación, haciendo uso de los sistemas de puntuación-recompensa-objetivo de los juegos. Existen distintas herramientas que se pueden utilizar en los entornos universitarios que permiten crear ejercicios, tareas o establecer recompensas e insignias, así como monitorizar el trabajo diario de los estudiantes, de tal modo que ellos avanzan en las tareas y ejercicios poniendo a prueba sus conocimientos. Se trabaja así con el refuerzo, apoyo y mejora académica que ayuda a aumentar el interés de los alumnos por su aprendizaje y facilita el acceso a la tecnología por parte de los docentes. En su mayoría estas herramientas se fundamentan en el aprendizaje basado en problemas, que se puede adaptar a los contenidos en cada caso mientras que los estudiantes aprenden jugando.

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ADESÃO A CUIDADOS PREVENTIVOS - CONTRIBUTOS PARA O PERFIL DE SAÚDE DE UMA COMUNIDADE: UM ESTUDO DESCRITIVO

ADHERENCE TO PREVENTIVE CARE - CONTRIBUTIONS TO A COMMUNITY'S HEALTH PROFILE: A DESCRIPTIVE STUDY

ADHERENCIA A ATENCIÓN PREVENTIVA - CONTRIBUCIONES AL PERFIL DE SALUD DE UNA COMUNIDAD: UN ESTUDIO DESCRIPTIVO

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RESUMO

Introdução: As doenças cérebro-cardiovasculares e oncológicas são responsáveis pela maioria das causas de morte em Portugal. Os profissionais de saúde, através de cuidados que visam manter ou melhorar a saúde individual e coletiva, atuam para a deteção precoce de problemas, perspetivando melhor qualidade de vida das pessoas e populações.
Objetivo: Avaliar a adesão de uma comunidade aos cuidados preventivos em saúde.
Método: Quantitativo descritivo observacional. A recolha de dados decorreu durante o mês de novembro de 2019. Amostra constituída por 567 sujeitos, com idade ≥ 15 anos, não probabilística, num município do Norte de Portugal. Recolha de dados pelo IV Inquérito Nacional de Saúde do Instituto Nacional de Saúde (Secção 7).
Resultados: Amostra maioritariamente feminina (54.9%), idade entre 25-64 anos (61.6%), com médico de família (97.9%) que tiveram consulta no último ano (67.7%). No grupo etário ≥65 anos, 57.3% vacinaram-se contra a gripe, em 2019. A taxa de adesão à avaliação da Tensão Arterial e do colesterol foi de 96.1% e 92.9%, respetivamente, da glicemia 85.6%. No rastreio de doenças oncológicas, a maior adesão verificou-se na citologia cérvico-vaginal (82.8%) e menor adesão para colonoscopia (55.9%). O motivo para realização destes rastreios foi, essencialmente, rotina.
Conclusão: Este estudo permitiu um maior conhecimento de uma população quanto à adesão a vacinação e rastreios, constatando-se boas taxas de adesão, e refletindo a intervenção dos profissionais de saúde. Observa-se, no entanto, necessidade de ensinar/demonstrar a técnica de auto-colheita de fezes, sobretudo nas pessoas com menor nível de escolaridade, e informar homens sobre vantagens do exame prostático.

Palavras-chave: saúde; prevenção; vacinação; rastreio; enfermagem comunitária

ABSTRACT

Introduction: Brain-cardiovascular and oncological diseases are responsible for most causes of death in Portugal. Health professionals, through preventive care, work in early detection, contributing to a better quality of life for people.
Objective: To assess the community's adherence to preventive health care.
Methods: quantitative descriptive observational. Sample, 567 subjects ≥ 15 years old, not probabilistic, in a municipality in Northern Portugal. Data collection by the IV National Health Survey of the National Health Institute (Section 7).
Results: mostly female sample (54.9%), 61.6% aged between 25-64 years, family doctor (97.9%) and of these, 67.7% had a health consultation in the last year. In 2019, of the sample 65 years or older, 57.3% were vaccinated against influenza. The adherence rate to blood pressure and cholesterol assessment was 96.1% and 92.9%, respectively, and glycaemia was 85.6%. The highest adherence was found in cervical cytology (82.8%) and the lowest adherence in colonoscopy (55.9%) concerning oncological diseases screening. The reason for performing these screenings was mostly for routine examination.
Conclusion: This study allowed a better understanding of the reality of the population regarding adherence to vaccination and screening, which has reasonable adherence rates, also exposing the intervention of health professionals in this regard. There will be a need to teach/demonstrate the self-collection technique of faeces, especially in populations with less education and advantages of the digital rectal examination, in men.

Keywords: health; prevention; vaccination; screenings; community nursing

RESUMEN

Introducción: Las enfermedades cerebro-cardiovasculares y oncológicas son responsables de la mayoría de las causas de muerte en Portugal. Los profesionales de la salud, a través de la atención preventiva, contribuyen a una mejor calidad de vida de las personas.
Objetivo: Evaluar la adherencia de una comunidad a la atención preventiva de la salud.
Métodos: observacional descriptivo cuantitativo. Muestra, 567 sujetos ≥ 15 años, no probabilista, en un municipio del norte de Portugal. Recolección de datos por la IV Encuesta Nacional de Salud, Instituto Nacional de Salud (Sección 7).
Resultados: amuestra mayoritariamente femenina (54.9%), 61.6% con edades comprendidas entre os 25-64 anos con médico de familia (97.9%) y 67.7% llevó a cabo una consulta de vigilancia en el último año. De los mayores de 65 años, 57.3% se vacunó contra la gripe, en 2019. La tasa de adherencia a la evaluación de la presión arterial y el colesterol fue del 96.1% y 92.9%, respectivamente y glucemia 85.6%. En cuanto a las enfermedades oncológicas, la mayor adherencia de los exámenes se encontró en citología cervical cervical (82.8%) y menor en colonoscopia (55.9%). Estos exámenes fueron mayormente de rutina.
Conclusión: Este estudio permitió conocer mejor la realidad de una población en la adherencia a vacunación y exámenes, presentando buenas tasas de adherencia. Aun así, será necesario enseñar/demostrar la técnica de autocolección de heces, especialmente en poblaciones con menor nivel educativo y ventajas del tacto rectal, en hombres.

Palabras Clave: salud; prevención; vacunación; tamizaje; enfermería comunitaria

INTRODUCTION

Preventive care aims to maintain and/or improve people's individual and collective health to ensure equity in health care to prevent disease. This care encompasses decisions and measures in all sectors of society, involving the community and various professional groups (Roksund, 2011). Nursing plays a fundamental role in health education (EPS) and other cares to prevent chronic diseases, accidents, premature death, and health damage. Thus, considering the mortality observed in Portugal concerning cerebrovascular diseases, endocrine and oncological diseases (Administração Regional de Saúde do Norte [ARS Norte, 2018]), a project articulated between the Escola Superior de Saúde de Viana do Castelo and one of the municipalities in the same district was built, to contribute to the construction of a health profile that would support the planning of projects in the area of health promotion. This study is part of the Municipal Health Survey carried out in that municipality, which aimed to obtain indicators on adherence to preventive health care in this population. It should be noted that this Municipal Health Survey was linked to the training processes of students of the Nursing degree in the Research curricular units, respectively, of the 3rd and 4th year, with the guidance of several professors.

For this partial study, we aimed to evaluate the adherence to preventive health care of the population of a municipality in the district of Viana do Castelo.

1. THEORETICAL FRAMEWORK

Preventive care is related to primary and secondary health prevention. For Stanhope et al. (2011), in primary prevention, interventions are oriented toward health promotion and disease prevention, using actions that enable people to act and manage health determinants, either in the field of environmental protection, or in the specific protection, while secondary prevention aims at interventions that increase the probability of an early diagnosis of diseases, using, for example, screening.

Health intervention, especially at the primary prevention level, is not exclusive to health services and professionals, although they have increased responsibility.

Health is essential to human life, giving rise to well-being, ability to work and personal happiness (Ferreira & Gonçalves 2015). The "Ordem dos Enfermeiros" (OE) also advocates that health is a state, but also the mental representation that each person has of their condition, associated with the control of suffering, the perception of physical well-being and emotional and spiritual comfort. Being a dynamic and continuous process, everyone wants to reach a state of balance in these different domains (OE, 2002).

Vaccination is one of the most effective health promotion and disease prevention measures, either by controlling or eliminating diseases at a low cost, overcoming the costs associated with treatment and complications related to the disease is a right of citizens in Portugal. The flu vaccination is recommended for people aged ≥ 65 years and other vulnerable groups and should be administered in the autumn or until the end of each calendar year (Direção Geral da Saúde [DGS, 2019]).

Screening has also low costs, being mainly recommended for diseases with a high prevalence and subject to early detection and appropriate treatment, with guidelines for the ages/groups in which they are most recommended (Stanhope & Lancanter, 2011). In Portugal, the DGS (2011, 2014, 2015, 2017) issued guidelines for screenings associated to preventing arterial hypertension, diabetes, dyslipidemia in adults and oncological diseases.

Analyzing the data for the triennium 2012-2014, we found out that found that the proportional mortality by large groups of death causes, both at the national level and the level of ARS Norte, for all ages and both sexes, showed decreasing rates in diseases of the circulatory and digestive system, in malignant tumours and endocrine diseases, among others with less expressiveness (ARS Norte, 2018).

In this context, the interest came up in this study, which aims to analyze how this population adheres to a health surveillance program, namely through vaccination, blood pressure (BP) and blood glucose and screening for breast, colon and prostate and cervix.

2. METHODS

The present study is part of the descriptive, observational and transversal type quantitative paradigm. Concerning the sample, and given the impossibility of studying the entire population of a municipality in the district of Viana do Castelo, due to limited time for the study and difficulty inaccessibility to the participants, a partnership was established between the Escola Superior de Saúde de Viana do Castelo and the municipality, selected by the autarchy, representative parishes of the geographic diversity and also of demographic characteristics. The sample size was calculated for a prevalence study, assuming a tolerable error of 4% and a confidence interval of 95%. The initial sample was stratified, proportionally, by parish, according to the resident population, an option that could not be ensured during data collection, as it was not possible to maintain the number of surveys foreseen by the parish, leading to underrepresentation in some parishes and an over-representation in others.

The Kish method was supposed to be used for the selection of sampling units. However, it was impossible to apply the surveys to households, as these are predominantly rural parishes with dispersed dwellings, and data collection was carried out at the headquarters of parish councils and other places with concentration of people, having to opt for an accidental sampling technique.

For the recruitment of the people to be surveyed, we counted with the collaboration of elements of the parish councils, who were asked to select according to the number of inquiries per parish, by sex and by age. However, it was observed that the distribution was not proportional according to sex and age group, and the sample was weighted according to these variables.

Thus, the sample consisted of 567 participants, 311 females and 256 males, aged between 15 and 94 years.

We used a questionnaire adapted from the IV National Health Survey (NHS), (Instituto Nacional de Estatística, Dr. Ricardo Jorge [INE, 2016]) for data collection. The data from this study refer to Section 7 of the questionnaire - Preventive Care - consisting of 24 questions with several response options that aim to assess people's adherence to preventive care, encompassing not only its practice but also the frequency and reason by which they perform.

Each group of questions had specific inclusion criteria. For this study, we considered an inclusion criteria, to be the participant to answer all questions. Thus, the first eleven questions and the last two were intended for all people aged ≥15 years. Questions regarding mammography and cervical-vaginal cytology were addressed to women aged ≥20 years. The colon and rectal cancer screening questions were aimed at men and women aged ≥50 years. The prostate cancer screening questions were only asked for men aged 50 and over. General questions were addressed to all participants.

The survey was carried on by a group of 4th year Nursing degree students, by interview, in an average time of 30 minutes, during November 2019.

The ethical principles and rights of the participants were safeguarded either through the guarantee of anonymity and confidentiality of the data or the freedom to accept or not to collaborate in the study without any prejudice to the non-acceptance. In order to guarantee the principle of free and informed consent, the objective and purposes of the study were also explained, validating together with the participants if they had understood everything or if there was any doubt.

Descriptive statistics were used to process the data, with distribution, location, and dispersion measures. The Statistical Package for the Social Sciences (SPSS) version 20 was used.

3. RESULTS

The sample was mostly female (n= 349; 54.7%), predominantly aged 25-64 years (61.6%). About half of them had completed basic education (50.8%), 97.9% had a family doctor, and 67.7% had had a health surveillance consultation in the last year. Regarding access to health services, 92.6% of the interviewees said they did not experience any difficulties; the constraints pointed out by the others were related to distance, waiting time, the transport network and timetable. It should be noted that the transport network was most mentioned by the elderly while waiting time and distance were the constraints most mentioned by all participants.

The influenza vaccine is administered annually, considering the variability of strains (DGS, 2019). As shown in Table 1, most respondents reported never having been vaccinated against influenza (64.6%). Of the people who claimed to have been vaccinated, it was in 2019 that the highest percentage (57.3%) was aged 65 years or over. A medical indication was the most mentioned reason for vaccination (64.2%), followed by advice from nurses (26%).

Table 1 - Distribution according to Influenza Vaccination

Flu vaccine	**%**
Vaccinated	34.7
Never been vaccinated	64.6
Doesn't know	0.7
Last flu vaccine	**%**
In 2019	57.3
In 2018	24.9
In 2017 or before	17.8
Vaccination mode	**%**
By doctor's recommendation	64.2
Recommended by other health professionals	26.0
Because I saw advertising	3.7
By advice from friends or family	3.1
Own initiative	2.5
Doesn't know	0.6

It was found (Table 2) that almost all people have evaluated the ED at some point in their lives (96.1%), and most have evaluated the ED for less than three months (68.6%). Concerning the cholesterol assessment, most had already performed the analysis (92.9%). Furthermore, their assessment prevails for less than a year in 74.4% of the participants and less than three months for 40.8%. Regarding blood glucose monitoring, 85.6% of them had already evaluated it, and the majority (45.2%) reported having evaluated it less than three months ago.

The most common reason for evaluating these three parameters was routine (TA 75.2% and cholesterol 82.7%) and glycemia for presenting complaints (84.7%). It was also found that the assessment of BP and cholesterol were more frequent among adults and the elderly.

Table 2 - Distribution according to the assessment of Blood Pressure, Cholesterol and Glycemia

Mammography		%	Cervical Cytology		%	Rectal touch		%
realized		69.5	realized		82.8	realized		56.8
never performed		30.5	never performed		17.2	never performed		43.2
Last review		**%**	**Last Rating**		**%**	**Last Rating**		**%**
50 - 69 years	2 years ago or less	81.4	<30 years	3 years ago or less	92.0	50 -75 years	2 years ago or less	57.1
				more than 3 years ago	8.0			
	more than 2 years ago	18.6	≥ 30 years	5 years ago or less	82.7		more than 2 years ago	42.9
				more than 5 years ago	17.3			
Reason for evaluation		**%**	**Reason for evaluation**		**%**	**Reason for evaluation**		**%**
disease control		2.9	disease control		0.8	disease control		5.4
disease screening		12.9	disease screening		10.6	disease screening		15.1
complaints		1.9	complaints		0.8	complaints		1.1
routine exam		82.4	routine exam		87.3	routine exam		78.5

One of the most frequent screenings is for breast cancer, using mammography, and for cervical cancer, using cervical-vaginal cytology. For this evaluation, women aged between 20 and 94 years were included, with an average of 53.88 years.

Regarding mammography, the age variable was operationalized according to the recommendations of DGS Norm 051/2011. The results revealed that in all women (n=311), 69.5% had already had a mammogram. It should be noted that 30.5% had never taken this exam. The majority of women who underwent this examination were aged from 50 to 69 years, and 81.4% of women underwent it two or less years ago. Cervicovaginal cytology was performed by most women (82.8%), mainly between 30 and 65 years old (81.6%). Of the total number of women (n=311), 75.3% underwent the examination less than three years ago, and 92% were less than 30 years old. Of the women over 30 years old, 82.7% had this screening for less than five years. The scaling of ages was operationalized according to the Portuguese Society of Gynecology (2014) recommendations.

These two screenings were mainly routine (mammography 82.4%; cytology 87.3%); the second reason was screening for disease (mammography 12.9% and cytology 10.6%) (Table 3).

Table 3 – Distribution according to adherence to Breast Cancer, Colon Cancer and Prostate Cancer Screenings

TA assessment	%	Cholesterol assessment	%	Blood glucose assessment	%
rated	96.1	rated	92.9	rated	85.6
never rated	1.6	never rated	3.2	never rated	10.8
Do not know	2.3	Do not know	3.9	Do not know	3.7
Last review	**%**	**Last Rating**	**%**	**Last Rating**	**%**
< to 3 months	68.6	< to 3 months	40.8	< to 3 months	45.2
between 3 -5 months	11.6	between 3 -5 months	17.5	between 3 -5 months	14.0
between 6 -11 months	6.4	between 6 -11 months	16.1	between 6 -11 months	17.3
between 1 -3 years	11.9	between 1 -3 years	21.8	between 1 -3 years	20.0
more than 3 years ago	1.5	more than 3 years ago	3.8	more than 3 years ago	3.5
Reason for evaluation	**%**	**Reason for evaluation**	**%**	**Reason for evaluation**	**%**
disease control	17.2	disease control	10.1	disease control	9.3
disease screening	5.0	dodge the illness	6.8	disease screening	6.0
had complaints	2.0	had complaints	0.4	had complaints	84.7
by routine exam	75.2	by routine exam	82.7	by routine exam	9.3
Do not know	0.6	Do not know	0.0	Do not know	6.0

Two tests perform colon cancer screening: colonoscopy and faecal occult blood test, recommended for both sexes, from 50 on. Thus, 295 people of both sexes were surveyed, aged between 50 and 94 years (DGS, Norm nº 003/2014), with an average age of 66.5 years. The occult blood test was the most frequent method, being mentioned by 60.4% of respondents, and of these, 79.6% mentioned having performed the test 2 years ago or less, with the predominant age group being between 50 and 74 years (84%). Colonoscopy was performed by 55.9%, with a predominance in the group from 50 to 74 years old (77%), in which 94.5% of them said they had performed this exam ten or less years ago. 75.3 % of the reasons for carrying it out were routine, while 19% for disease screening and 3.2% for disease control.

Prostate cancer screening is performed by prostatic examination, digital rectal examination, and Prostate Specific Antigen (PSA) test is indicated from 50 on, so the questions were addressed to men aged 50 and over (DGS, 2017). PSA was evaluated by 65.9%

of men and prostate examination by 56.8 %, with a higher prevalence from 50 to 75 years old (86.9%), and of these, 57.1% performed this screening for less than two years.

Regarding the need for prostate examination, the majority reported it routinely (78.5%), followed by screening for the disease (15.1%), with 5.4% still reporting disease control, similar to the reasons for PSA assessment (Table 3).

4. DISCUSSION

Based on the results obtained, the sample is predominantly female, with low education and ages between 25-64 years, in line with the data from the last Census (2021).

The surveyed population revealed excellent accessibility to health services. The majority reported having a health surveillance consultation in 2019, which may imply that they are aware of the importance of self-responsibility in preventing, protecting, and promoting their own health. Several factors may contribute to these results, such as the educational interventions of health professionals from local and other units, as well as the media, social networks, and informal support.

Difficulties in accessing care are few relate mostly to waiting time service and distance. Older people probably use the public transport network the most, and refer its inadequate adaptation to their needs. Accessibility could be optimized, for example, by creating mobile units. However, operationally, there is a need for better knowledge of the available human and material resources and a cost-benefit assessment.

According to the results of the survey, vaccination rate was low, which may be explained by the time of data collection (1st fortnight of November) and the predominance of people aged between 25 and 64 in the sample, with the vaccine, recommended mainly in priority groups, aged 65 years or older, chronically ill~~,~~ and immunocompromised and other at-risk groups (Portugal, 2019). During data collection, it was also possible to perceive that the advantages of this vaccine are still not very clear to most respondents, which, in turn, may affect adherence to it. Thus, a more significant investment is required of health professionals in terms of health promotion and education regarding the importance of this prophylatic for influenza, as well as the risk that the disease entails. Tones and Tilford (1994), cited by Carvalho & Carvalho (2006), refer to health education as a planned professional activity that facilitates learning related to health and illness, and which is expected to produce changes in knowledge understanding and ways of thinking about others.

Considering the chronic illnesses, with the highest prevalence at the national level which include those, associated with Arterial Hypertension (HTA), hypercholesterolemia (DGS, 2015) and hyperglycemia high adherence was observed, in the assessment/monitoring of BP, cholesterol and blood glucose, and this level was higher than that observed at the national level (INE, 2016), with health surveillance being the main rationale given. It should be noted that hypertension is the most closely monitored risk factor, as shown by the percentage presented. The greater adherence to the assessment of AT may result from the fact that it is a non-invasive measure and performed routinely in health consultations, at the pharmacy or even at home, while other monitoring implies more invasive procedures, such as clinical analyzes and other screenings. It should be noted that the percentage of people who evaluated the AT in the last year is higher than that presented in the National Health Survey (NHS) of 2014 (INE, 2016) by around 10%. According to this survey, 2.2 million people (25.3%) reported having hypertension, which represents an increase of 23.4% compared to 2005/2006. The portrait of Health (Portugal, 2018) confirms this trend, noting that hypertension affects 36% of the Portuguese from the age of 25 to 74, and cerebrovascular diseases accounted for 29.7% of deaths in 2015 in Portugal.

Hyperglycemia is one of the leading causes of diabetes which, according to data published in 2018, affected 10% of the Portuguese population aged from to 74, especially in older age groups (Portugal, 2018). The concern of individuals and health professionals is related to the fact that this disease has a growing prevalence. According to the Portuguese Society of Diabetology (2016), by 2040, one in 10 adults will have diabetes. For these same reasons, it is essential to invest in the prevention of modifiable risk factors to reverse the increasing trend of this health problem that causes high morbidity and mortality. On the one hand, in people with diabetes, the blood glucose assessment is a means of monitoring the disease, allowing the analysis of the variation in blood glucose levels, also understanding whether they adopt healthier lifestyle habits and/or if changes in pharmacological treatment are required. On the other hand, even in people without this pathology, periodic monitoring is essential since changes in glucose metabolism, or other factors may increase the levels in the blood.

It should be noted that 17.2%, 10.1% and 9.3% of respondents monitored, respectively, BP, cholesterol and blood glucose for disease control. In this sense, it is essential, in addition to pharmacological measures, health promotion and educational interventions aimed at physical activity, healthy eating and obesity prevention.

Cancer is one of the leading causes of death, representing the second leading cause in Portugal (Portugal, 2018). In oncological disease screenings, the analysis followed national and international recommendations regarding the age when the respective screening exams began, with high adherence to cervical-vaginal cytology (82.8%), higher than the one observed in the NHS, which was 70.7% (INE, 2016), and lower concerning mammography (69.5%), being lower than the national results of 2014 (84.2%). It should be noted that the majority of women who underwent mammography were in the 50 to 69 age group, strongly recommended, having performed the exam less than two years ago, data overlapping with those of the NHS, reporting that 84.2%

of women, in this age group, they underwent a mammogram in the two years prior to the interview (INE, 2016). Given that there are still no effective measures to prevent or cure breast cancer and that more than 90% of women with this pathology can be cured if diagnosed at an early stage, this screening can be a very effective measure (DGS, 2011). A significant part of this sample (n=96; 31%) underwent mammography before the age of 50, age and younger than that recommended by the DGS, probably due to morphological changes and/or presenting symptoms (DGS, 2011). It is also crucial to mention that a significant percentage of the sample has never undergone this test (29.1%), which may correspond to women with ages marginal to those recommended to undergo the test.

In colorectal cancer screening, faecal occult blood tests and a colonoscopy were performed by more than half of the respondents and for the majority, two years or less than ten years before, respectively, mainly for routine examination. The rate of adherence to colonoscopy in the ten years prior to the survey is higher than the national results of the NHS (INE, 2016), which was 35.1%.

Regarding screening for prostate cancer, the percentage of PSA tests was higher than that of digital rectal examination. This discrepancy may be related to the fact that the latter is a more invasive test, physically and psychologically than the PSA test based on blood analysis. Digital rectal examination is still a taboo subject for some men, which was also observed during the surveys due to the discomfort caused by the questions in some interviewees. More than half had a digital rectal screening; however, only about 1/3 of men had it less than three years ago. Compared to the results obtained in the NHS 2014, the percentage of completion of the PSA is similar (66.6%). However, comparing the rate of digital rectal examination in the present study (57.1%) it appears to be higher than that observed in the NHS 2014, which was 32.1% (INE, 2016).

CONCLUSION

As in any other area, research plays a fundamental role in health, as it allows the evolution of knowledge and contributes to the improvement of professional practice. By supporting practice on scientific evidence, professionals improve the quality of their practice, both in terms of health promotion and protection, disease prevention and treatment, resulting in better health for people, groups, and the community.

The surveyed population reveals excellent accessibility to health services, the difficulties ~~are~~ mentioned by around 8% of respondents, mostly related to waiting time in services and distance.

Standard No. 006/2019 recommends vaccinating priority target groups regarding the flu vaccine. According to the survey data, the vaccination rate was low, and it is necessary to invest in greater awareness of the importance of the seasonal flu vaccine, given the predominance of older people.

In the BP, cholesterol, and blood glucose assessment, high adherence was observed, being health surveillance, the main reason mentioned. However, it should be noted that hypertension is the disease with the highest prevalence in the population, so there are more references to assessment for disease control in this population. In this sense, it is crucial ~~to~~ disease control measures, health promotion and education measures, and oriented toward physical activity and healthy eating.

In general, in this study, high adherence to screenings was observed, the main reason being routine exams, which highlights the concern of health professionals with anticipatory care and users with the maintenance of their health and disease prevention. Despite reasonable membership rates, it is desirable to improve your coverage. To this end, as there are several screenings, it may be necessary to invest more in raising the population's awareness of the importance of preventive care, making them collectively and individually responsible for their health. There may still be a need to improve rates of breast exams in the recommended groups and teach/demonstrate the performance of self-collection of faeces samples, especially in the poorest and least educated population, as well as helping to overcome male barriers concerning to digital rectal examination.

The results of this study present some limitations that condition its generalization, namely the non-probabilistic sampling technique, the impossibility of using the Kish method, as initially foreseen, the sample not keeping the proportionality in terms of sex and age group by parish, being the enquired population, primarily elderly, even though the interview technique was used to motivate people to respond, and because most of the questions were related to people's perception, not using objective observation measures.

Despite the methodological limitations, it is expected that the study will allow a better understanding of the health reality in this municipality regarding preventive care (vaccination and screening exams) and that it will contribute to the construction of projects in the area of health promotion, with the involvement of municipal officials responsible for the social and health area and of health professionals, namely nurses in Primary Health Care.

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ADESÃO A CUIDADOS PREVENTIVOS - CONTRIBUTOS PARA O PERFIL DE SAÚDE DE UMA COMUNIDADE: UM ESTUDO DESCRITIVO

ADHERENCE TO PREVENTIVE CARE - CONTRIBUTIONS TO A COMMUNITY'S HEALTH PROFILE: A DESCRIPTIVE STUDY

ADHERENCIA A ATENCIÓN PREVENTIVA - CONTRIBUCIONES AL PERFIL DE SALUD DE UNA COMUNIDAD: UN ESTUDIO DESCRIPTIVO

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RESUMO

Introdução: As doenças cérebro-cardiovasculares e oncológicas são responsáveis pela maioria das causas de morte em Portugal. Os profissionais de saúde, através de cuidados que visam manter ou melhorar a saúde individual e coletiva, atuam para a deteção precoce de problemas, perspetivando melhor qualidade de vida das pessoas e populações.
Objetivo: Avaliar a adesão de uma comunidade aos cuidados preventivos em saúde.
Método: Quantitativo descritivo observacional. A recolha de dados decorreu durante o mês de novembro de 2019. Amostra constituída por 567 sujeitos, com idade ≥ 15 anos, não probabilística, num município do Norte de Portugal. Recolha de dados pelo IV Inquérito Nacional de Saúde do Instituto Nacional de Saúde (Secção 7).
Resultados: Amostra maioritariamente feminina (54.9%), idade entre 25-64 anos (61.6%), com médico de família (97.9%) que tiveram consulta no último ano (67.7%). No grupo etário ≥65 anos, 57.3% vacinaram-se contra a gripe, em 2019. A taxa de adesão à avaliação da Tensão Arterial e do colesterol foi de 96.1% e 92.9%, respetivamente, da glicemia 85.6%. No rastreio de doenças oncológicas, a maior adesão verificou-se na citologia cérvico-vaginal (82.8%) e menor adesão para colonoscopia (55.9%). O motivo para realização destes rastreios foi, essencialmente, rotina.
Conclusão: Este estudo permitiu um maior conhecimento de uma população quanto à adesão a vacinação e rastreios, constatando-se boas taxas de adesão, e refletindo a intervenção dos profissionais de saúde. Observa-se, no entanto, necessidade de ensinar/demonstrar a técnica de auto-colheita de fezes, sobretudo nas pessoas com menor nível de escolaridade, e informar homens sobre vantagens do exame prostático.

Palavras-chave: saúde; prevenção; vacinação; rastreio; enfermagem comunitária

ABSTRACT

Introduction: Brain-cardiovascular and oncological diseases are responsible for most causes of death in Portugal. Health professionals, through preventive care, work in early detection, contributing to a better quality of life to people.
Objective: To assess a community's adherence to preventive health care.
Methods: quantitative descriptive observational. Sample, 567 subjects ≥ 15 years old, not probabilistic, in a municipality in Northern Portugal. Data collection by the IV National Health Survey of the National Health Institute (Section 7).
Results: mostly female sample (54.9%), 61.6% aged between 25-64 years, family doctor (97.9%) and of these 67.7% had a health consultation in the last year. In 2019, the sample 65 years or older, 57.3% were vaccinated against influenza. The adherence rate to the assessment of blood pressure and cholesterol was 96.1% and 92.9%, respectively, and glycaemia, 85.6%. With regard to oncological diseases screening, the highest adherence was found in cervical cytology (82.8%) and lower adherence in colonoscopy (55.9%). The reason for performing these screenings was mostly for routine examination.
Conclusion: This study allowed a better understanding of the reality of a population regarding adherence to vaccination and screening, which has good adherence rates, also exposing the intervention of health professionals in this regard. Even so, there will be a need to teach/demonstrate the technique of self-collection of feces, especially in populations with less education and advantages of digital rectal examination, in men.

Keywords: health; prevention; vaccination; screenings; community nursing

RESUMEN

Introducción: Las enfermedades cerebro-cardiovasculares y oncológicas son responsables de la mayoría de las causas de muerte en Portugal. Los profesionales de la salud, a través de la atención preventiva, contribuyen a una mejor calidad de vida de las personas.
Objetivo: Evaluar la adherencia de una comunidad a la atención preventiva de la salud.
Métodos: observacional descriptivo cuantitativo. Muestra, 567 sujetos ≥ 15 años, no probabilista, en un municipio del norte de Portugal. Recolección de datos por la IV Encuesta Nacional de Salud, Instituto Nacional de Salud (Sección 7).
Resultados: amuestra mayoritariamente femenina (54.9%), 61.6% con edades comprendidas entre os 25-64 anos con médico de familia (97.9%) y 67.7% llevó a cabo una consulta de vigilancia en el último año. De los mayores de 65 años, 57.3% se vacunó contra la gripe, en 2019. La tasa de adherencia a la evaluación de la presión arterial y el colesterol fue del 96.1% y 92.9%, respectivamente y glucemia 85.6%. En cuanto a las enfermedades oncológicas, la mayor adherencia de los exámenes se encontró en citología cervical cervical (82.8%) y menor en colonoscopia (55.9%). Estos exámenes fueron mayormente de rutina.
Conclusión: Este estudio permitió conocer mejor la realidad de una población en la adherencia a vacunación y exámenes, presentando buenas tasas de adherencia. Aun así, será necesario enseñar/demostrar la técnica de autocolección de heces, especialmente en poblaciones con menor nivel educativo y ventajas del tacto rectal, en hombres.

Palabras Clave: salud; prevención; vacunación; tamizaje; enfermería comunitaria

INTRODUÇÃO

Os cuidados preventivos visam manter e/ou melhorar a saúde individual e coletiva das pessoas, perspetivando a garantia da equidade nos cuidados de saúde, a fim de prevenir a doença. Estes cuidados abrangem decisões e medidas em todos os setores da sociedade, envolvendo não só a comunidade como diversos grupos profissionais (Roksund, 2011). A Enfermagem desempenha um papel fundamental, intervindo tanto na educação para a saúde (EPS) como em outros cuidados, com o objetivo de prevenir as doenças crónicas, acidentes, morte prematura e malevolência em saúde. Assim, considerando a mortalidade verificada em Portugal, relativamente a doenças cérebro-cardiovasculares, doenças endócrinas e oncológicas (Administração Regional de Saúde do Norte [ARS Norte, 2018]), construiu-se um projeto, articulado entre a Escola Superior de Saúde de Viana do Castelo e um dos municípios do mesmo distrito, com vista a contribuir para a construção de um perfil de saúde que apoiasse o planeamento de projetos na área da promoção da saúde. Este estudo constitui uma parte do Inquérito Municipal de Saúde levado a cabo nesse concelho, que visou obter indicadores sobre a adesão aos cuidados de saúde preventivos desta população. De referir que este Inquérito Municipal de Saúde articulou-se com os processos formativos dos estudantes do Curso de Licenciatura em Enfermagem (CLE), nas unidades curriculares de Investigação, respetivamente do 3º e 4º ano, com a orientação de vários professores.

Para este estudo parcelar traçamos como objetivo avaliar a adesão aos cuidados preventivos em saúde da população de um município do distrito de Viana do Castelo.

1. REVISÃO DA LITERATURA

Os cuidados preventivos relacionam-se com a prevenção primária e secundária em saúde. Para Stanhope e colaboradores (2011), na prevenção primária, as intervenções orientam-se para a promoção da saúde e a prevenção da ocorrência de doença, recorrendo-se a ações que capacitem as pessoas para agir e gerir os determinantes de saúde, quer seja no domínio da proteção ambiental, como na proteção específica, enquanto a prevenção secundária visa intervenções que aumentem a probabilidade de diagnóstico precoce de doenças, recorrendo, por exemplo, a rastreios.

A intervenção em saúde, sobretudo ao nível da prevenção primária, não é exclusividade dos serviços de saúde e dos seus profissionais, ainda que tenham responsabilidade acrescida.

A saúde é algo essencial à vida humana, originando bem-estar, capacidade de trabalho e felicidade pessoal (Ferreira & Gonçalves 2015). A Ordem dos Enfermeiros (OE) advoga, igualmente, que a saúde é um estado, mas também a representação mental que cada pessoa tem da sua condição individual, associada ao controlo do sofrimento, à perceção de bem-estar físico e conforto emocional e espiritual. Sendo um processo dinâmico e contínuo, toda a pessoa deseja atingir o estado de equilíbrio nestes diferentes domínios (OE, 2002).

A vacinação é uma das medidas mais eficazes na promoção da saúde e na prevenção da doença, quer pelo controlo ou eliminação de doenças, a baixo custo, superando os gastos associados ao tratamento e às complicações ligadas à doença, sendo um direito dos cidadãos, em Portugal. A vacinação contra a gripe está recomendada a pessoas com idade ≥ a 65 anos, e a outros grupos vulneráveis, devendo ser administrada no outono ou até ao fim de cada ano civil (Direção Geral da Saúde [DGS, 2019]).

Os rastreios têm, igualmente, baixos custos, sendo sobretudo recomendados para doenças com elevada prevalência e que possam ser passíveis de deteção precoce e de tratamento adequado, havendo orientações para as idades/grupos em que são mais aconselhados (Stanhope & Lancanter, 2011). Em Portugal, a DGS (2011, 2014, 2015, 2017) emanou um conjunto de normas orientadoras para os rastreios associados à prevenção da hipertensão arterial, diabetes, dislipidemias no adulto e de doenças oncológicas.

Analisando os dados referentes ao triénio 2012-2014, verificou-se que a mortalidade proporcional por grandes grupos de causas de morte, quer ao nível nacional quer ao nível da ARS Norte, para todas as idades e ambos os sexos, apresentou taxas decrescentes nas doenças do aparelho circulatório e digestivo, nos tumores malignos e nas doenças endócrinas, entre outras com menor expressividade (ARS Norte, 2018).

Neste contexto, surgiu o interesse neste estudo que pretende analisar de que forma esta população adere a um programa de vigilância de saúde, nomeadamente através da vacinação, monitorização da Tensão Arterial (TA) e da glicemia e aos rastreios das neoplasias da mama, colon e próstata e colo do útero.

2. MÉTODOS

O presente estudo inscreve-se no paradigma quantitativo, do tipo descritivo, observacional e transversal.

No que diz respeito à amostra, e na impossibilidade de se estudar toda a população de um concelho do distrito de Viana do Castelo, por limitação de tempo para o estudo e dificuldade na acessibilidade aos participantes, estabeleceu-se uma parceria entre a Escola Superior de Saúde de Viana do Castelo e o Município, sendo selecionadas pela autarquia, freguesias representativas da diversidade geográfica e das características populacionais do mesmo. O tamanho da amostra foi calculado para um estudo de prevalência, assumindo um erro tolerável de 4% e um intervalo de confiança da 95%. A amostra inicial era estratificada, proporcionalmente, por freguesia, de acordo com a população residente, opção que não se conseguiu assegurar durante a colheita de dados, por não ser possível manter o número de inquéritos previstos por freguesia, conduzindo a uma sub-representação em algumas freguesias e uma sobre-representação noutras.

Previa-se a utilização do método de *Kish* para a seleção das unidades amostrais. No entanto, não se conseguiu a aplicação dos inquéritos nos domicílios, dado tratar-se de freguesias predominantemente rurais e com habitações dispersas, sendo a recolha de dados efetuada nas sedes das juntas de freguesias e em outros locais de concentração de pessoas, tendo de se optar por uma técnica de amostragem acidental. Para o recrutamento das pessoas a inquirir contou-se com a colaboração de elementos das juntas de freguesia, a quem foi solicitada a seleção de acordo com o número de inquéritos por freguesia, por sexo e por idade. Contudo, observou-se que a distribuição não era proporcional em função do sexo e do grupo etário, tendo a amostra sido ponderada em função destas variáveis.

Assim, a amostra ficou constituída por 567participantes, sendo 311 do sexo feminino e 256 do sexo masculino, com idades compreendidas entre 15 e 94 anos.

Para a colheita de dados, recorreu-se a um questionário adaptado do IV Inquérito Nacional de Saúde (Instituto Nacional de Saúde Dr. Ricardo Jorge [INE, 2016]). Os dados deste estudo dizem respeito à Secção 7 do questionário – Cuidados Preventivos – constituída por 24 questões com várias opções de resposta que pretendem avaliar a adesão das pessoas aos cuidados preventivos, englobando não só a sua prática, como também, a periodicidade e a razão pela qual os efetuam.

Cada grupo de questões tinham critérios de inclusão específicos. Para este estudo consideramos, como critério de inclusão para todas as questões, ser o próprio a responder. Deste modo, as primeiras onze questões e as duas últimas foram destinadas a todas as pessoas com idade ≥15 anos. As questões relativas à mamografia e citologia cérvico-vaginal foram dirigidas a mulheres com idade ≥20 anos. Já as questões relativas ao rastreio do cancro do cólon e reto destinavam-se a homens e mulheres com idade ≥ 50 anos. As questões relativas ao rastreio do cancro da próstata foram apenas colocadas a homens com 50 e mais anos. As questões de âmbito geral destinavam-se a todos os participantes.

O inquérito foi aplicado por um grupo de estudantes do 4º ano do CLE, por entrevista, num tempo médio de 30 minutos, durante o mês de novembro de 2019.

Salvaguardaram-se os princípios éticos e direitos dos participantes, quer através da garantia do anonimato e confidencialidade dos dados, quer da liberdade de aceitar ou não colaborar no estudo, sem qualquer prejuízo para o próprio, a não aceitação. Para garantirmos o princípio do consentimento livre e informado, também foi explicado o objetivo e finalidades do estudo, validando junto dos participantes se tinham compreendido tudo ou havia alguma dúvida.

Para tratamento dos dados, recorreu-se à estatística descritiva, com medidas de distribuição, localização e dispersão. Para isso, utilizou-se o programa *Statistical Package for the Social Sciences* (SPSS) versão 20.

3. RESULTADOS

A amostra foi maioritariamente do género feminino (n=349; 54.7%), com idade predominante entre 25-64 anos (61.6%). Relativamente à escolaridade, cerca de metade detinha o ensino básico (50.8%), 97.9% tinham médico de família e 67.7% realizaram consulta de vigilância de saúde no último ano. Relativamente ao acesso aos serviços de saúde, 92.6% dos entrevistados referiu não sentir dificuldade, os constrangimentos apontados pelos restantes relacionavam-se com a distância, o tempo de espera, a rede de transportes e horário. De salientar que a rede de transportes foi mais mencionada pelas pessoas mais idosas, enquanto o tempo de espera e a distância foram as condicionantes mais apontadas por todos os participantes.

A vacina da gripe é administrada anualmente, tendo em consideração a variabilidade das estirpes (DGS, 2019). Como se constata na tabela 1, a maioria dos inquiridos referiu nunca se ter vacinado contra a gripe (64.6%). Das pessoas que afirmaram ter-se vacinado, foi no ano 2019 que se verificou a maior percentagem (57.3%) com idade igual ou superior a 65 anos. A indicação médica foi a razão mais mencionada para a vacinação (64.2%), seguida do aconselhamento por parte de enfermeiros (26 %).

Tabela 1 – Distribuição em função da Vacinação contra a Gripe

Vacina contra a gripe	**%**
Vacinou-se	34.7
Nunca se vacinou	64.6
Não sabe	0.7
Última vacina contra a gripe	**%**
Em 2019	57.3
Em 2018	24.9
Em 2017 ou antes	17.8
Motivo da vacinação	**%**
Por indicação do médico	64.2
Por indicação de outros profissionais de saúde	26.0
Porque vi publicidade	3.7
Por aconselhamento de amigos ou familiares	3.1
Iniciativa própria	2.5
Não sabe	0.6

Constatou-se (Tabela 2) que quase todas as pessoas já avaliaram a TA em algum momento da sua vida (96.1%) e a maioria avaliou a TA há menos de três meses (68.6%). No que se refere à avaliação do colesterol, a maioria já tinha realizado a análise (92.9%). Para além disso, constata-se que prevalece a sua avaliação há menos de um ano em 74.4% dos participantes e há menos de três meses para 40.8%. Quanto à vigilância da glicemia, 85.6% deles já avaliou alguma vez e a maioria (45.2%) referiu ter avaliado há menos de 3 meses.

A razão mais comum para a avaliação destes três parâmetros foi rotina (TA 75.2% e colesterol 82.7%) e a glicemia, por apresentarem queixas (84.7%). Constatou-se, ainda, que a avaliação da TA e do colesterol foi mais frequente entre adultos e idosos

Tabela 2 – Distribuição em função da avaliação da Tensão Arterial, Colesterol e Glicemia

Avaliação da TA	**%**	**Avaliação do colesterol**	**%**	**Avaliação da glicemia**	**%**
Avaliou	96.1	Avaliou	92.9	Avaliou	85.6
Nunca avaliou	1.6	Nunca avaliou	3.2	Nunca avaliou	10.8
Não sabe	2.3	Não sabe	3.9	Não sabe	3.7
Última avaliação	**%**	**Última Avaliação**	**%**	**Última Avaliação**	**%**
< a 3 meses	68.6	< a 3 meses	40.8	< a 3 meses	45.2
Entre 3 a 5 meses	11.6	Entre 3 a 5 meses	17.5	Entre 3 a 5 meses	14.0
Entre 6 e 11 meses	6.4	Entre 6 e 11 meses	16.1	Entre 6 e 11 meses	17.3
Entre 1 e 3 anos	11.9	Entre 1 e 3 anos	21.8	Entre 1 e 3 anos	20.0
Há mais de 3 anos	1.5	Há mais de 3 anos	3.8	Há mais de 3 anos	3.5
Motivo da avaliação	**%**	**Motivo da avaliação**	**%**	**Motivo da avaliação**	**%**
Controlo da doença	17.2	Controlo da doença	10.1	Controlo da doença	9.3
Despiste da doença	5.0	Despiste da doença	6.8	Despiste da doença	6.0
Tinha queixas	2.0	Tinha queixas	0.4	Tinha queixas	84.7
Por exame de rotina	75.2	Por exame de rotina	82.7	Por exame de rotina	9.3
Não sabe	0.6	Não sabe	0.0	Não sabe	6.0

Um dos rastreios mais frequentes é o do cancro da mama, através da mamografia, e o do cancro do colo do útero, pela citologia cérvico-vaginal. Para esta avaliação incluíram-se as mulheres com idades compreendidas entre 20 e 94 anos, sendo a média de 53.88 anos.

Relativamente à mamografia, a variável idade foi operacionalizada segundo as recomendações da Norma nº 051/2011 da DGS. Os resultados revelaram que na totalidade das mulheres (n=311), 69.5% já realizaram uma mamografia. De salientar que 30.5% nunca realizou este exame. A maioria das mulheres que realizou este exame encontra-se no grupo etário dos 50 aos 69 anos e 81.4% das mulheres realizou-a há 2 anos ou menos. A citologia cérvico-vaginal foi realizada pela maioria das mulheres (82.8%), principalmente entre os 30 e 65 anos (81.6%). Do total das mulheres (n=311), 75.3% realizaram o exame há menos de 3 anos e 92% delas tinham menos de 30 anos de idade. Das mulheres com mais de 30 anos, 82.7% realizou este rastreio há menos de 5 anos. O escalonamento das idades foi operacionalizado segundo as recomendações da Sociedade Portuguesa de Ginecologia (2014).

A realização destes dois rastreios, foi sobretudo por rotina (mamografia 82.4%; citologia 87.3%), o segundo motivo foi, despiste de doença (mamografia 12.9% e citologia 10.6%) (Tabela 3).

O rastreio do cancro do cólon é efetuado por dois exames: colonoscopia e pesquisa de sangue oculto nas fezes, recomendado para ambos os sexos, a partir dos 50 anos. Assim, foram inquiridas 295 pessoas de ambos os sexos, com idades compreendidas entre os 50 e os 94 anos (DGS, Norma nº 003/2014), sendo a média das idades de 66.5 anos. A pesquisa de sangue oculto foi o método mais frequente, sendo referido por 60.4% dos inquiridos, e destes, 79.6% mencionou ter realizado o exame há 2 anos ou menos, sendo o grupo etário predominante o dos 50 aos 74 anos (84%). A colonoscopia foi efetuada por 55.9%, com predomínio no grupo dos 50 aos 74 anos (77%), em que 94.5% destes, afirmaram ter realizado este exame há 10 anos ou menos. Sobre as razões para a sua realização 75.3% referiu por rotina, enquanto 19% para despiste de doença e 3.2% para controlo de doença.

O rastreio do cancro da próstata é efetuado pelo exame prostático, através de toque rectal, e pela pesquisa do *Prostate Specific Antigen* (PSA*),* sendo indicado a partir dos 50 anos, pelo que as questões foram dirigidas a homens com 50 e mais anos (DGS, 2017). O PSA foi avaliado por 65.9% dos homens e o exame prostático por 56.8%, com maior prevalência entre os 50 e os 75 anos (86.9%), sendo que destes, 57.1% efetuou este rastreio há menos de 2 anos.

Em relação à necessidade do exame prostático, a maioria referiu por rotina (78.5%), seguido de despiste de doença (15.1%), havendo ainda 5.4% que reportou o controlo da doença, sendo semelhantes às razões para avaliação do PSA (Tabela 3).

Tabela 3 – Distribuição em função da adesão aos Rastreios do Cancro da Mama, Cancro do Colón e Cancro da Próstata

Mamografia		**%**	**Citologia Cervical**		**%**	**Toque rectal**		**%**
Realizou		69.5	Realizou		82.8	Realizou		56.8
Nunca realizou		30.5	Nunca realizou		17.2	Nunca realizou		43.2
Última avaliação		**%**	**Última Avaliação**		**%**	**Última Avaliação**		**%**
50 – 69 anos	Há 2 anos ou menos	81.4	<30 anos	Há 3 anos ou menos	92.0	50 –75 Anos	Há 2 anos ou menos	57.1
				Há mais de 3 anos	8.0			
	Há mais de 2 anos	18.6	≥ 30 anos	Há 5 anos ou menos	82.7		Há mais de 2 anos	42.9
				Há mais de 5 anos	17.3			
Motivo da avaliação		**%**	**Motivo da avaliação**		**%**	**Motivo da avaliação**		**%**
Controlo da doença		2.9	Controlo da doença		0.8	Controlo da doença		5.4
Despiste doença		12.9	Despiste doença		10.6	Despiste doença		15.1
Queixas		1.9	Queixas		0.8	Queixas		1.1
Exame de rotina		82.4	Exame de rotina		87.3	Exame de rotina		78.5

4. DISCUSSÃO

Pelos resultados obtidos, predomina na amostra o sexo feminino, baixa escolaridade e idades entre 25-64 anos, indo ao encontro dos dados do último Censos (2021).

A população inquirida revelou excelente acessibilidade aos serviços de saúde e a maioria referiu ter uma consulta de vigilância de saúde no ano de 2019, podendo significar que está sensibilizada para a importância e para a autoresponsabilização na prevenção, proteção e promoção da sua saúde. Vários fatores podem concorrer para estes resultados, tais como a intervenção educativa dos profissionais de saúde das unidades locais e outras, bem como os meios de informação, as redes sociais e de suporte informal.

As dificuldades no acesso aos cuidados são reduzidas, sendo maioritariamente relacionadas com o tempo de espera nos serviços e a distância. As pessoas mais idosas são, provavelmente, as que mais utilizam a rede de transportes públicos, referindo a inadequação às suas necessidades. A acessibilidade poderia ser otimizada, por exemplo, com a criação de unidades móveis. No entanto, para a sua operacionalização há necessidade de melhor conhecimento sobre recursos humanos e materiais disponíveis e, ainda, a avaliação do custo-benefício.

De acordo com os resultados do inquérito, a taxa de vacinação foi baixa, o que se pode justificar pelo momento de recolha de dados (1ª quizena de novembro) e na amostra predominarem pessoas com idades compreendidas entre os 25 e os 64 anos, sendo a vacina recomendada, principalmente, em grupos prioritários, com idade igual ou superior a 65 anos, doentes crónicos, imunodeprimidos e outros grupos de risco (Portugal, 2019). Durante a recolha de dados foi, também, possível perceber que as vantagens desta vacina ainda não estão bem claras para a maioria dos inquiridos, o que, por sua vez, pode condicionar a adesão à mesma. Assim, implica por parte dos profissionais de saúde um maior investimento na promoção e educação para a saúde relativa à importância deste meio preventivo da gripe, assim como do risco que a doença comporta. Tones e Tilford (1994), citados por Carvalho & Carvalho (2006), referem-se à educação para a saúde como uma atividade profissional intencional facilitadora de aprendizagens relacionadas com saúde e doença, esperando-se que produza mudanças no conhecimento, na compreensão e nas formas de pensar no outro.

Considerando as doenças crónicas, com maior prevalência ao nível nacional, associadas à Hipertensão Arterial (HTA), hipercolesterolémia (DGS, 2015) e hiperglicemia, na avaliação/monitorização da TA, do colesterol e da glicemia observou-se elevada adesão, superior ao verificado ao nivel nacional (INE, 2016), sendo a vigilância da saúde a principal razão apontada. É de destacar que a HTA é o fator de risco mais vigiado, como se observa pela percentagem apresentada. A maior adesão na avaliação da TA, pode decorrer do facto de ser uma medida pouco invasiva e efetuada por rotina nas consultas de saúde, na farmácia ou até em casa, enquanto que outras monitorizações implicam procedimentos mais invasivos, como as análises clínicas e outros rastreios. Salienta-se que a percentagem de pessoas que avaliaram a TA no último ano é superior à apresentada no Inquérito Nacional de Saúde (INS) de 2014, (INE, 2016) em cerca de 10%. Segundo os resultados deste Inquérito, 2,2 milhões de pessoas (25,3%) referiram ter HTA, o que representa um aumento de 23.4% face a 2005/2006. O retrato da Saúde (Portugal, 2018) confirma esta tendência, salientando que a HTA afeta 36% dos portugueses entre os 25 e os 74 anos e as doenças cérebro-cardiovasculares representaram 29.7% das mortes ocorridas no ano de 2015 em Portugal.

A hiperglicemia é uma das principais causas da diabetes que, segundo dados publicados em 2018, afetava 10% da população portuguesa entre os 25 e os 74 anos, sobretudo nos grupos etários com mais idade (Portugal, 2018). A preocupação individual, mas também dos profissionais de saúde, relaciona-se com o facto de esta doença apresentar uma prevalência em crescendo. Segundo a projeção da Sociedade Portuguesa de Diabetologia (2016), em 2040, um em cada 10 adultos terá diabetes. Por estas mesmas razões, é fundamental investir na prevenção de fatores de risco modificáveis, na tentativa de inverter a tendência de aumento deste problema de saúde que causa elevada morbilidade e mortalidade. Em pessoas com diabetes diagnosticada, a avaliação da glicemia constitui um meio de monitorização da doença, permitindo analisar a variação dos níveis glicémicos, perceber se adotam hábitos de vida mais saudáveis e/ou se são necessárias alterações no tratamento farmacológico. Por outro lado, mesmo em pessoas sem esta patologia é essencial um controlo periódico, uma vez que alterações no metabolismo da glicose, ou outras, podem conduzir ao aumento dos seus níveis no sangue.

De salientar que 17.2%, 10.1% e 9.3% dos inquiridos monitorizavam, respetivamente, a TA, o colesterol e a glicemia para controlo de doença. Neste sentido, é importante, para além das medidas farmacológicas, intervenções de promoção e educação para a saúde orientadas para a atividade física, alimentação saudável e prevenção da obesidade.

O cancro é uma das principais causas de morte, representando a segunda causa em Portugal (Portugal, 2018). Nos rastreios da doença oncológica, a análise seguiu as recomendações nacionais e internacionais quanto à idade de início dos respetivos exames de rastreio, observando-se uma grande adesão para a citologia cérvico-vaginal (82.8%), superior à observada no INS, que foi de 70.7% (INE, 2016), e menor relativamente à mamografia (69.5%), sendo inferior aos resultados nacionais de 2014 (84.2%). De notar que a maioria das mulheres que realizou mamografia estava no grupo etário dos 50 aos 69 anos, em que é fortemente recomendada, tendo realizado o exame há menos de 2 anos, dados sobreponíveis aos do INS, ao reportarem que 84.2% das mulheres, nesta faixa etária, realizaram uma mamografia nos dois anos anteriores à entrevista (INE, 2016). Atendendo a que ainda não existem medidas efetivas para prevenir ou curar o cancro da mama, e que mais de 90% das mulheres com esta patologia podem ser curadas se diagnosticadas num estádio precoce, este rastreio pode ser uma medida muito eficaz (DGS, 2011). Uma parte significativa desta amostra (n=96; 31%) realizou mamografia antes dos 50 anos, idade inferior à recomendada pela DGS, provavelmente por alterações morfológicas e/ou apresentarem sintomas (DGS, 2011). Torna-se ainda crucial referir que há uma percentagem significativa da amostra que nunca realizou este exame (29.1%), podendo corresponder às mulheres com idades marginais às recomendadas para realizar o exame.

No rastreio do cancro colorretal, a pesquisa de sangue oculto nas fezes, bem como, a colonoscopia, foram efetuadas por mais de metade dos inquiridos e para a maioria, há 2 anos ou menos de 10 anos, respetivamente, sobretudo por exame de rotina. A taxa de adesão à realização da colonoscopia, nos 10 anos anteriores ao inquérito, é superior aos resultados nacionais do INS (INE, 2016), que foi de 35.1%.

Em relação aos rastreios da neoplasia prostática, a percentagem de testes de PSA foi mais elevada do que a do toque rectal. Esta discrepância poderá estar relacionada com o facto deste último ser um exame mais invasivo, física e psicologicamente, do que o teste PSA a partir de análise sanguínea. O toque rectal constitui ainda para alguns homens um assunto tabu, que também foi constatado aquando da realização dos inquéritos, pelo desconforto que as questões suscitaram, em alguns entrevistados. No geral, mais de metade fez o rastreio com toque rectal, no entanto só cerca de 1/3 dos homens o realizou há menos de 3 anos. Comparando com os resultados obtidos no INS 2014, constata-se que a percentagem da realização do PSA é semelhante (66.6%). Todavia, comparando a taxa de realização do toque rectal no presente estudo (57.1%) verifica-se ser mais elevada do que a observada no INS de 2014, que foi de 32.1% (INE, 2016).

CONCLUSÃO

A investigação, tal como em qualquer outra área, assume na saúde um papel fundamental, na medida em que permite a evolução do conhecimento e contribui para a melhoria da prática profissional. Ao sustentar a prática na evidência científica, os profissionais melhoram a qualidade no seu exercício, quer ao nível da promoção e proteção da saúde, como da prevenção e do tratamento da doença, resultando em melhor saúde das pessoas, dos grupos e da comunidade.

A população inquirida revela uma excelente acessibilidade aos serviços de saúde e as dificuldades são referidas por cerca de 8% dos inquiridos, sendo maioritariamente relacionadas com tempo de espera nos serviços e a distância.

Relativamente à vacina contra a gripe, a norma nº 006/2019 recomenda a vacinação dos grupos alvo prioritários. De acordo com os dados do inquérito, a taxa de vacinação foi baixa, sendo de investir na maior sensibilização para a importância da vacina da gripe sazonal, dada a predominância de pessoas idosas.

Na avaliação da TA, do colesterol e da glicemia verificou-se elevada adesão, sendo a vigilância em saúde a principal razão apontada. No entanto, é de salientar que a HTA é a doença com maior prevalência na população, sendo por isso também nesta que se encontram mais referências à avaliação para controlo da doença. Neste sentido, é importante, para além das medidas de controlo da doença, medidas de promoção e educação para a saúde, orientadas para a atividade física e para a alimentação saudável.

De uma forma geral observou-se, neste estudo, uma elevada adesão aos rastreios, sendo a principal razão os exames de rotina, o que evidencia a preocupação dos profissionais de saúde com os cuidados antecipatórios e dos utentes com a manutenção da sua saúde e a prevenção da doença. Apesar das boas taxas de adesão é desejável melhorar a sua cobertura. Para tal, porque estão instituídos diversos rastreios, poderá ter de se investir mais na sensibilização da população para a importância dos cuidados preventivos, corresponsabilizando-a coletiva e individualmente pela sua saúde. Pode haver ainda necessidade de melhorar as taxas dos exames mamários nos grupos recomendados e ensinar/demonstrar a realização da auto-colheita de fezes, sobretudo nas populações com menor escolaridade, bem como, ajudar a ultrapassar barreiras masculinas ao toque rectal.

Os resultados deste estudo apresentam algumas limitações que condicionam a sua generalização, nomeadamente a técnica amostral não probabilística, a impossibilidade de utilizar o método de *Kish*, como inicialmente previsto, a amostra não manter a proporcionalidade quanto ao sexo e grupo etário por freguesia, a população inquirida ser maioritariamente idosa, ainda que se tenha utilizado a técnica de entrevista para motivar as pessoas a responder, e pelo facto da maioria das questões ser relativa à perceção das pessoas, não se utilizando medidas de observação objetivas.

Apesar das limitações metodológicas, espera-se que o estudo permita um melhor conhecimento da realidade em saúde deste município, quanto aos cuidados preventivos (vacinação e exames de rastreio) e que contribua para a construção de projetos na área da promoção da saúde, com envolvimento de responsáveis autárquicos pela área social e da saúde e de profissionais de saúde, nomeadamente, enfermeiros dos Cuidados de Saúde Primários.

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CONJUGALIDADES E INTERAÇÕES FAMILIARES DE CASAIS EM "NINHO VAZIO": ANÁLISE BASEADA NO MODELO DINÂMICO DE AVALIAÇÃO E INTERVENÇÃO FAMILIAR

EMPTY NEST COUPLES' CONJUGALITIES AND FAMILY INTERACTIONS: ANALYSIS BASED ON THE DYNAMIC MODEL OF FAMILY ASSESSMENT AND INTERVENTION

CONYUGALIDADES E INTERACCIONES FAMILIARES DE PAREJAS EN "NIDO VACÍO": ANÁLISIS BASADA EN EL MODELO DINÁMICO DE EVALUACIÓN E INTERVENCIÓN FAMILIAR

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RESUMO

Introdução: A etapa do ciclo de vida das famílias em que os filhos adultos saem de casa, expressa-se por alterações na dinâmica das famílias, implicando reorganização conjugal e redefinição das relações entre pais e filhos.
Objetivo: Analisar a perceção de casais sobre a sua conjugalidade em "ninho vazio"; analisar o desenvolvimento de casais e a funcionalidade de famílias em "ninho vazio"; descrever a adaptação dos casais à saída dos filhos adultos de casa; analisar os recursos que facilitaram a adaptação dos casais a esta fase.
Métodos: Estudo descritivo exploratório de abordagem qualitativa. Participaram oito casais heterossexuais em "ninho vazio" (N = 16). Amostra recolhida por "bola de neve". Utilizada entrevista semiestruturada para recolha da informação. Tratamento e análise dos dados realizados através da análise de conteúdo de Bardin, com categorias baseadas no Modelo Dinâmico de Avaliação e Intervenção Familiar.
Resultados: Os casais adaptam-se gradualmente às alterações inerentes à saída dos filhos de casa. Mostram-se satisfeitos com a conjugalidade e com a interação mantida com os filhos. As divergências comunicacionais são ultrapassadas, não prejudicando o desenvolvimento conjugal. As estratégias de coping foram eficazes. Nas mulheres, nota-se maior necessidade na dedicação a interesses e atividades lúdicas e de lazer.
Conclusão: Os casais estão satisfeitos com a sua conjugalidade, adaptaram-se bem à saída dos filhos e abriram-se à família. O enfermeiro de saúde familiar foi reconhecido como recurso facilitador deste processo de adaptação.

Palavras-chave: "Relação marital"; "ninho vazio"; "enfermagem familiar"; "satisfação conjugal"; "Modelo de Avaliação e Intervenção Familiar"

ABSTRACT

Introduction: Changes in family dynamics mark the phase in the family life cycle when adult children leave home. These changes involve marital reorganization and redefining the relationships between parents and children.
Objective: To explore couples' perspectives on their empty nest conjugality, analyze couples' development and empty nest families' functioning, describe couples' adaptation to their adult children's departure, and examine the resources facilitating couples' adaptation to this phase.
Methods: This is a descriptive exploratory study with a qualitative approach. The sample, recruited using the snowball method, consisted of eight heterosexual empty nest couples (N = 16). Information was collected using semi-structured interviews. The data were treated and analyzed using Bardin's content analysis, with categories based on the Dynamic Model of Evaluation and Family Intervention.
Results: The couples gradually adapted to the changes caused by their children's departure. They were satisfied with their conjugality and the interaction maintained with their children. Communication differences were overcome and did not harm the marital development. The coping strategies were effective. Female participants showed a greater need to dedicate themselves to interests and recreational and leisure activities.
Conclusion: The couples were satisfied with their conjugality, adapted well to their children's departure, and opened to the family. The Family Health nurse was recognized as a facilitating agent in this adaptation process.

Keywords: "Marital relationship"; "empty nest"; "family nursing"; "marital satisfaction"; "Model of Family Assessment and Intervention"

RESUMEN

Introducción: La etapa del ciclo de vida de las familias en que los hijos adultos dejan el hogar se expresa por cambios en la dinámica familiar, lo que implica reorganización conyugal y redefinición de las relaciones entre padres e hijos.
Objetivo: Analizar la percepción de las parejas sobre su conyugalidad en el "nido vacío"; analizar el desarrollo de las parejas y la funcionalidad de las familias en el "nido vacío"; describir la adaptación de las parejas cuando sus hijos adultos salir del hogar; analizar los recursos que facilitaron la adaptación de las parejas en esta fase.
Métodos: Estudio exploratorio descriptivo con abordaje cualitativa. Participaron ocho parejas heterosexuales en "nido vacío" (N = 16). Muestra recolectada por "bola de nieve". Para la recolección de la información se utilizó la entrevista semiestructurada. Procesamiento y análisis de datos realizado a través del análisis de contenido de Bardin, con categorías basadas en el Modelo Dinámico de Evaluación e Intervención Familiar.
Resultados: Las parejas se adaptan gradualmente a los cambios inherentes a la salida de sus hijos del hogar. Están satisfechos con la conyugalidad y con la interacción mantenida con los hijos. Se superan las divergencias comunicacionales, no perjudicando el desarrollo conyugal. Las estrategias de afrontamiento fueron efectivas. En las mujeres existe una mayor necesidad de dedicación a intereses y actividades lúdicas y de ocio.
Conclusion: Las parejas están satisfechas con su conyugalidad, se han adaptado bien a la partida de sus hijos y se han abierto a la familia. Lo enfermero de salud de la familia fue reconocido como un recurso que facilita ese proceso de adaptación.

Palabras Clave: "Relacion matrimonial"; "ninho vazio"; "Enfermería de la Familia"; "satisfacción conyugal"; "Modelo Dinámico de Evaluación e Intervención Familiar"

INTRODUCTION

Family is a dynamic system that evolves over time, with bonds or relationships in which each member has roles and functions. It is the first institution for individual socialization and development, presenting as primary functions the support and protection of its members and the formation of the person's family role (Relvas, 1996). According to Wrigth & Leahey (2013), the family can be defined by who its members say they are, emphasizing the respect for significant relationships and becoming relevant in the systemic approach to Family Care.

The family life cycle phase characterized by adult children leaving home, also known as the empty nest, brings new tasks to the family members. The restructuring of conjugality and family interactions can cause difficulties and new needs. Thus, conjugality becomes a challenge for couples whose children leave home, as they have to review their priorities and refocus on conjugality.

Family Health Nursing care is aimed at the family unit and its responses to transitions. Empowering families to develop skills that allow them to adapt to the processes of change is an essential focus of this Nursing area. Thus, by analyzing empty nest families from a developmental and functional perspective, it is possible to understand their trajectory, implement anticipatory care related to the development of essential tasks foreseen for each phase, and prepare the family for future transitions (Figueiredo, 2012).

The Nurse Specialist in Community Nursing, in the area of Family Health Nursing, considers "... the family as a unit of care, promotes its empowerment by focusing on the family as a whole and its members throughout the life cycle and its transitions." (Ordem dos Enfermeiros, 2018, p. 19357). To facilitate family responses during complex transitions, nurses' specific skills include analyzing family dynamics and identifying their difficulties, strengths, and growth potential in the face of change, promoting the family's awareness process regarding these aspects, exploring strategies and resources to improve family dynamics, and encouraging more supportive relationships (Ordem dos Enfermeiros, 2018).

This study aims to contribute to the quality of nursing practices in this transitional phase of the family life cycle. It is based on the research question "How do empty nest couples perceive their conjugality and family interactions?" and guided by the following objectives: to explore couples' perspectives on their empty nest conjugality, analyze couples' development and empty nest families' functioning, describe couples' adaptation to their adult children's departure, and examine the resources facilitating couples' adaptation to this phase.

1. THEORETICAL FRAMEWORK

The phase in the family life cycle when adult children leave their parents' home is called "family with adult children" (Relvas, 1996), "launching the children and moving on" (Carter & McGoldrik, 1995), or "empty nest." This phase is characterized by recognizing the adult state and independence of the children, which leads to the expression of emotional ambivalence and demands the renewal of conjugality (Thapa et al., 2018).

The term "empty nest" is not consensual. Its conceptualization, in the 1930s, expressed a depressive dimension of family life, not very favorable to its necessary restructuring (Relvas, 1996). Nevertheless, the term has taken root in the literature. Today, the empty nest is discussed according to two perspectives: the pathological, associated with a depressive state, and the positive transformative, related to the renewal of marital life.

Considering the pathological perspective, empty nest syndrome is a psychological condition that affects both parents when their children leave home. It is characterized by the experience of feelings of grief, loss, fear, helplessness, difficulty in adjusting to new roles, and changes in parental relationships (Bougea et al., 2019). This phase can be emotionally difficult for parents who experience feelings of sadness, loneliness, and insecurity, as their children's independence can cause changes in their lives (Kaur & Kaur, 2021).

On the other hand, in its transformative perspective, the empty nest can be an exciting experience for the couple, becoming an enriching, productive, and creative transition which revives their relationship. It is an opportunity for reconnection, a time for renewing old friendships and hobbies, rekindling interests, continued personal growth, self-acceptance, and improved quality of life (Bougea et al., 2019; Fonseca et al., 2022; Kaur & Kaur, 2021).

Understanding their children's departure as a new adventure for development, rather than a loss, will help parents work through the absence of their child(ren) from their home and learn to cope with the void associated with the so-called empty nest syndrome (Kaur & Kaur, 2021). However, significant challenges are posed to the ability to resume or renew marital intimacy, possibly overshadowed by the parental role and lost over the years (Thapa et al., 2018).

Marital satisfaction relates to relationship stability, strategies to manage differences, quality of daily interactions, respect, admiration, and gratitude for the spouse, fostering acceptance, appreciation, and trust (Chaskelmann, 2020). Thus, empty nest couples need to share their innermost feelings, support each other, and physically and emotionally care for one another to reconnect in their conjugality (Thapa et al., 2018).

However, some studies argue that there is no significant change in couples' lives after their nests are empty (Fonseca et al., 2022).

Through their therapeutic interventions, nurses help families develop interaction patterns adequate to the changes experienced throughout the family life cycle and adopt more efficient and effective coping strategies. The Nurse Specialist in Community

Nursing in the area of Family Health Nursing is responsible for carrying out interventions that promote couples' empowerment to cope with the challenges of family life cycle transitions, thus reducing their negative impacts.

The Dynamic Model of Family Assessment and Intervention (MDAIF) is an interactive and flexible model with a multidimensional approach focused on family interactions and the complexity of the family system. It allows identifying families' needs and resources, establishing priorities, and planning and implementing interventions. It also encourages families' participation in the whole process to find solutions that promote change and restore families' healthy functioning, thus strengthening the family unit (Figueiredo, 2012). Figure 1 illustrates the MDAIF and its three evaluation dimensions, which are essential and relevant in delivering nursing care to families.

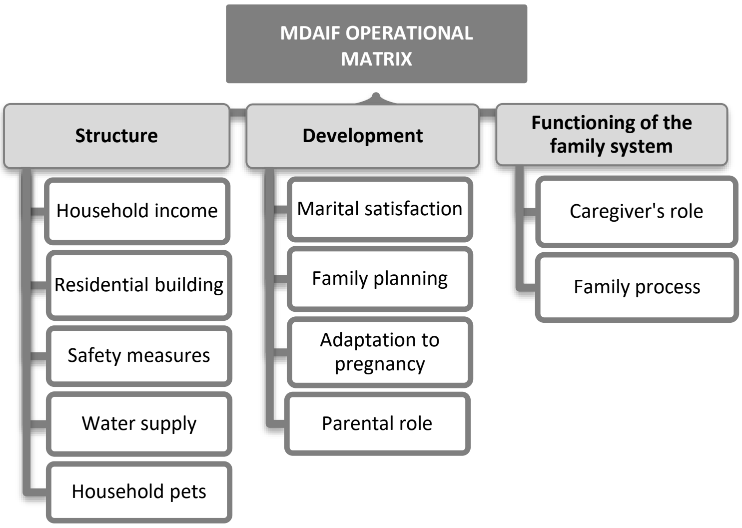

Figure 1 - Areas of Intervention by evaluative domains

Studies on nursing interventions facilitating the transition in the family life cycle when children leave home are scarce. Therefore, it is essential to know families' development and functioning to ground Family Health nurses' interventions.

2. METHODS

2.1 Sample

This is an exploratory-descriptive qualitative study, with the participation of 16 individuals forming eight couples in the empty nest phase. The sample was non-probabilistic and recruited using the "snowball" sampling technique (Coutinho, 2022) until data saturation was reached. The inclusion criteria were to be a heterosexual couple with children, married or in a de facto relationship, with an empty nest for more than six months. Couples with at least one child at home were excluded.

All ethical principles were met, and the Ethics Committee of the Health Sciences Research Unit approved this study (opinion no. 704/ 09-2020).

2.2 Data collection tools

Data were collected through semi-structured interviews, developed through a script with four open-ended questions and one question for sociodemographic characterization. During the interviews, these questions were complemented to allow for greater flexibility and freer and non-standardized data collection (Coutinho, 2022). The audio-recorded interviews were conducted individually to avoid participants feeling embarrassed about their answers. Due to couples' preference, the interviews took place at their homes between December 2020 and February 2021, following the COVID-19 prevention measures. The interviews were transcribed in full and content analysis was performed (Bardin, 2018). The participants' language was respected in the transcription, and conventions were used to record comments, interpolations, pauses, and silences.

2.3 Data analysis

The MDAIF (Figueiredo, 2012) was used to analyze and organize the data into areas of attention, operational dimensions, categories, subcategories, and record units, considering their similarities and the thematic convergence of the content of the narratives, thus achieving the results and allowing their discussion.

The characteristics of the MDAIF and its dynamic, flexible, collaborative, and interactive nature make it essential for knowing, assessing, understanding, and caring for families as a unit of care within PHC and Family Health Nursing and justify the choice of this theoretical framework.

Two outside judges, experts in the categorization system, validated the analysis, adding rigor to the study.

3. RESULTS

Considering the MDAIF (Figueiredo, 2012), the presentation of the results begins with the "Structure" dimension, identifying the family composition, family type, and extended family.

The study sample consisted of eight heterosexual couples who made up the household, married or in a de facto relationship, between 32 and 50 years old. The women's mean age was 61.9 years, and the men's was 66.3 years. Half of the couples had one biological child (50%), and the other half had two biological children (50%). Of the couples with two children, one had a deceased child. The couples had been in an empty nest for a mean of 8.1 years (between 15 months and 14 years).

Next, the presentation of results continues with the "Development" and "Functioning of the family system" dimensions and their areas of attention, operational dimensions, categories, subcategories, and record units. The "Development" dimension allows understanding phenomena related to families' growth and evolution in their life path (Figueiredo, 2012). The areas of attention "Marital Satisfaction" and "Parental Role" were identified in this dimension, as shown in Figure 2.

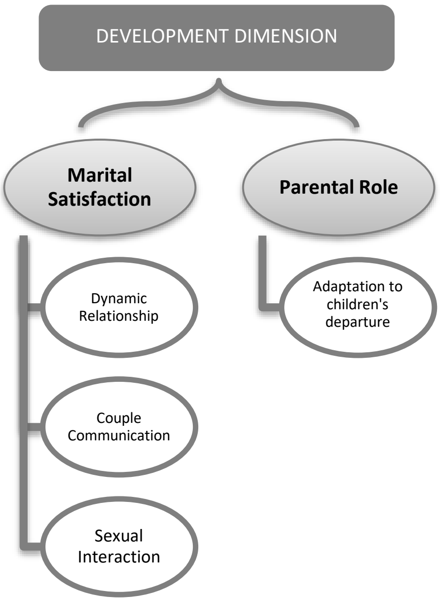

Figure 2 - Areas of attention and operational dimensions of the "Development" dimension

Marital Satisfaction focuses on the marital processes associated with the continuity of a satisfying relationship, understood as supporting the various interconnected aspects (Figueiredo, 2012). In this dimension, the participants' discourses focused on the following operational dimensions: Relationship Dynamics, Couple Communication, and Sexual Interaction. There were no narratives on sexual function, as illustrated in Figure 3.

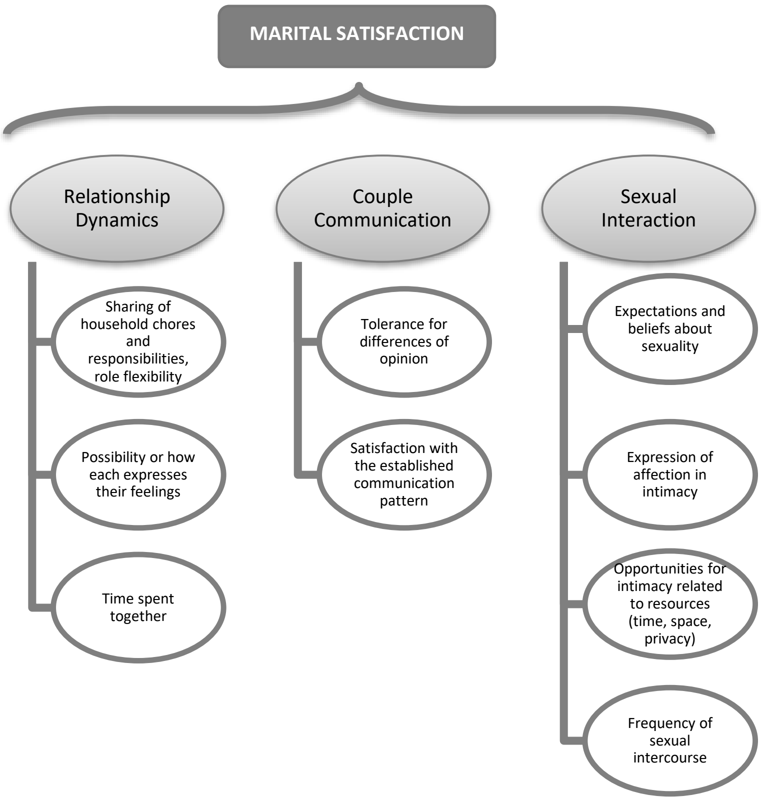

Figure 3 - Operational dimensions of the area of attention "Marital Satisfaction."

In the operational dimension "Relationship Dynamics," the category "Sharing of household chores and responsibilities, role flexibility" shows couples' reorganization after their children's departure - "*Yes, in fact, I share more tasks now than before"* (H2), or their maintenance of daily routines and responsibilities - "*Tasks were already shared ... our routines stayed the same*" (H4).

The category "Possibility or how each one expresses their feelings regarding their spouse" shows evidence of favorable aspects - "*It's just the two of us ... we are more united ..." (M5); "Our word is unity (...) there is always that void, and we have to be more and more united*" (H4).

Couples mentioned that after their children left home, the time spent together was a source of satisfaction - "*We have more time, I have more time for him and he for me*." (M5), for shared interests and joint activities - "(...) *hikes and walks, everything with him, together*." (M2). However, although without harming the couples' relationship dynamics, some narratives pointed out signs of dissatisfaction - "*It is true that she sometimes ... is more evasive than me or more than I would like ... Maybe I would even like to go for walks, but she prefers to stay... at home*" (H7).

Still, in this category, it is possible to observe that the Covid-19 pandemic impacted the participants' conjugality. It forced them to do more activities at home, or in its vicinity, and to socialize less - "*... normally when I went shopping, he would always go with me, now with Covid, he doesn't. Normally he doesn't want to go, because of the pandemic (...)"* (M6).

In the operational dimension "Couple Communication," the category "Tolerance for differences of opinion" was identified - *"... it is true that sometimes we disagree with each other, but it can be solved, most couples have these things..."* (H7).

The category "Satisfaction with the established communication pattern" was identified in some participants' narratives - *"... today, looking at the situation, we are certainly closer to each other, we talk a lot more ...*" (H7). However, not all participants expressed this satisfaction. Some reported changes due to the lack of dialogue - "*Sometimes I think we don't talk enough, we sometimes run away from certain situations, and we bypass them (...), to avoid conflicts*" (H6).

Understood as the relationship attributes that include the values and attitudes related to the expression of sexuality (Figueiredo, 2012), the operational dimension "Sexual Interaction" was organized into four categories presented below.

Considering the category "Expectations and beliefs about sexuality," one of the couples identified differences regarding sexuality. These differences were attributed to the lack of affection in the spouse's family of origin - "*... I don't know if it has something to do with the way he was raised (...) his parents were very cold people and never knew how to give love and I was raised poor, but with a lot of love (...)*" (M7).

In the category "Expression of affection in intimacy," the narratives revealed satisfied participants - "... *Intimately, I think we are more open (...) closer to one another...*" (H6). However, some participants mentioned that intimacy with their spouses had become less expressive - "In terms of affect *(...)* it broke a bit. Not for her but for me *(...)*" (H3).

Concerning the category "Opportunities for intimacy related to resources (time, space, privacy)," the analysis showed differences of opinion among spouses. Female participants denied changes - "*In terms of time, willingness, exchange of caresses? .... No, I don't think so, it hasn't changed at all*" (M6). On the other hand, the male participants reported an improvement in their intimate relationship - "*things have changed... we have more freedom... we feel more at ease...*" (H6).

Finally, the "Frequency of sexual intercourse" was influenced by aspects inherent to each spouse and not directly attributed to their children's departure - "*In terms of married life, it has more to do with the couple's disposition (...) the changes that may occur are also related with age, disposition, tiredness... It's not the children's departure*" (M2).

Still, within the "Development" dimension, the area of attention "Parental Role" refers to the family roles characterized by the family members' behavioral patterns regarding their expectations and beliefs about the role resulting from the functional model of the system and the cultural factors underlying it (Figueiredo, 2012). The content analysis revealed narratives only in the operational dimension "Family adaptation to children's departure" and its categories, as shown in Figure 4.

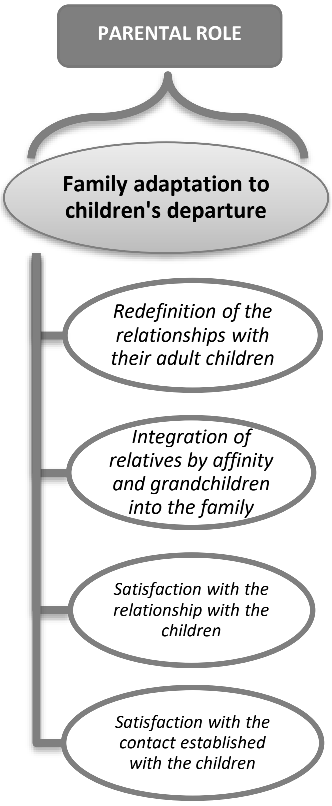

Figure 4 - Operational dimension and categories of the area of attention "Parental Role."

Several phases were observed in the category "Redefinition of the relationships with their adult children" and differentiated according to the accounts of the moment of transition. The phase immediately after the children's departure seems to have been experienced as an empty nest. Nevertheless, as time went by, the feelings were overcome, revealing a balanced adaptation - "*Yes, I missed them, I missed them, I felt sad, a bit of nostalgia, we were alone... but then with time everything goes away...*" (H5).

Two subcategories were identified: "The financial support for the children" and "The supportive relationship between parents and adult children." The subcategory "The financial support for the children" demonstrated that children's departure from home sometimes implies an increase in parents' expenses as they help their children financially and with the purchase of essential goods - "*... we give her close to 500 euros every month (...)*" (H3). In the subcategory "The supportive relationship between parents and adult children," it is possible to observe relationship reciprocity, concern for the well-being, and mutual help, indicating that the adaptation to this stage was achieved gradually, with the balanced redefinition of roles - *"... so [we] the parents are here to help in whatever is needed and then we also count on them*" (H4); "*If he has any problems, he calls us (...) if we have problems, we call him, and he corresponds to our call, we do the same thing (...)*" (H8).

In the category "Integration of relatives by affinity and grandchildren into the family," the analysis revealed that couples welcomed and accepted all members, facilitating the creation of interactional bonds - "*R. is like another son (...) he is an asset*" (M5); "*They come here with the kids, and we are always playing (...). We have three grandchildren, two twins, and a little girl...*" (H5).

The "Satisfaction with the relationship with the children" was evident, even in families whose children were geographically distant - *"... even far away he is always present. So much so that the day I shaved my hair he shaved his there! And while talking to me on Facebook."* (M1); *"The ties continue, the bonds have not been cut, quite the opposite..."* (H7).

The category "Satisfaction with the contact established with the children" was identified and highly valued in the participants' narratives. The contact softens the void caused by the children's absence and provides reassurance by proving that they are well - "*Very important (...) by how they answer or how I see them through the video call, I know how they are (...) Talking to them, listening to their voice, I can tell right away if they are well or not*" (M6).

This category also includes the "Changes in contact with their children due to the pandemic." For some couples, the pandemic delayed the reunion with their children who emigrated. For others, it prevented them from visiting each other, socializing, and doing activities together - *"...but if it was not for Covid, he would already be here, he had everything arranged to come in June but then this delayed everything..."* (M1).

Next, the "Functioning of the family system" dimension is presented. This dimension refers to the levels of "... *family interaction that allow performing family functions and tasks based on the functional complementarity that supports the system and the values that allow achieving its purposes, through the co-evolving processes that ensure continuity*" (Figueiredo, 2012). As shown in Figure 5, the areas of attention identified in this dimension were "Caregiver's Role" and "Family Process."

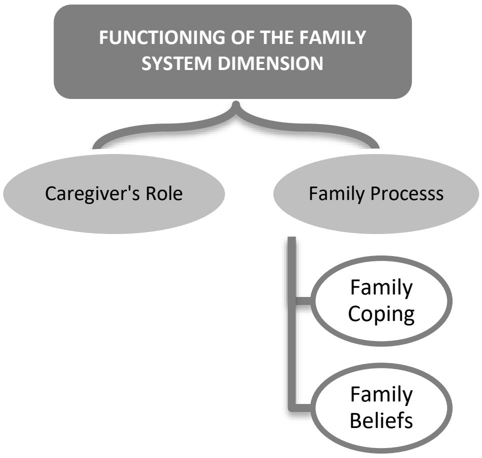

Figure 5 - Areas of attention and operational dimensions of the "Functioning of the family system" dimension

The Caregiver's Role represents an added responsibility with dependent elderly parents and the consequent need to provide care and/or one of the spouses' illness. Aging and dependency are relevant issues and represent challenges for the younger generation, whose parents are in their care - "*I had my mother sick, my father stayed home alone, and we had to alternate (...) something could happen, right? They needed us...*" (H4). By interfering with the functional and self-care ability, the illness of one member of the couple led the spouse to provide all the expected support, with this role being valued and recognized - "*He helped me in my illness, without a doubt (...) He was my driver, he was my husband, he was my nurse, he was my everything*" (M3).

The "Family Process" operational dimensions are "Family Coping" and "Family Beliefs." Considering "Family Coping," only the women mentioned the need for facilitating resources - "*I had my time occupied (...), and I had friends, yes (...) we went out for coffee, had tea in the pastry shop*" (M3). The category "Family Beliefs" presents the spiritual beliefs and values. The participants demonstrated having accepted and adapted gradually to their children's departure based on the belief that this was the normal course of life - "*Children are only ours when they are little. (...) life is just like that ... children cannot live at home forever, so parents (...) have to think that they have to let go*" (M7).

Beliefs about health professionals' interventions were also observed. Most of the participants recognized that the Family Health nurse could support them in redefining their conjugality. They specified that the Family Health nurse should pay attention to signs of adaptation difficulties in order to intervene - "*The nurse (...) could (...) direct us to what we should do to feel better, provide advice (...)*" (M8).

4. DISCUSSION

At this phase of the family life cycle, according to Costa (2018), *marital satisfaction* is characterized by role redefinition, relationship reconstruction, and continuity of daily activities without significant changes in the couples' lives.

Living together in conjugality leads to creating habits and routines, requiring an adjustment in perspectives, expectations, and behaviors towards the other. As Porreca (2019) and Silva et al. (2017) argue, the ability to renounce, give, talk, and be flexible contributes to balancing the relationship dynamics and strengthening the marital relationship.

The *couples' time* provided an opportunity to discover new interests and shared activities, as mentioned by Costa (2018). The couples under study saw these activities limited by the pandemic phase and confinement. Nevertheless, unlike Silva et al. (2020), the pandemic did not negatively affect these couples' conjugality. Some reported becoming closer, using creativity and good humor to overcome adversities. Several authors (Falcão et al., 2020; Kaur & Kaur, 2021) have described this closeness during the empty nest phase. Thus, it is impossible to attribute it only to the time experienced in pandemic confinement.

Regarding the established *communication* pattern, Chaskelmann (2020) notes that those who feel closer to their spouse tend to invest more in the relationship, providing it with stability. Moreover, when faced with conflict situations, the couples' best strategy, as described in other studies (Silva et al., 2017), may appears to be to avoid the confrontation and exacerbation of marital conflicts, maintain silence and reflect individually in order to understand the partner.

Regarding *sexual interaction*, each one's beliefs and expectations and the length of the marital relationship allowed one or both spouses to accept, adjust to, and understand each one's individuality, corroborating Porreca's findings (2019). The expressions of affection and sexuality are experienced accordingly to the individuality and the marital model co-constructed over the years. Thus, the differences found in the participants' narratives can be considered functional in a marital relationship, as individual and marital subsystems are articulated within a relationship, allowing its development (Silva et al., 2017).

The *opportunities for intimacy* related to resources (time, space, and privacy) allowed the sexual adjustment and acceptance of each other's physical changes. They also contributed to increasing marital satisfaction, namely the *frequency of sexual intercourse* (Rocha & Fensterseifer, 2019). However, following the traditional models, this study's female participants denied the existence of any differences regarding this topic. In contrast, the male participants reported greater satisfaction with the current availability and space for the couple.

The *parental role*, very specific to this phase of the family life cycle, proves to be controversial in what concerns the redefinition of the relationship with adult children, as couples' pride in their children for the autonomy achieved coexists with the concern and sadness due to distance.

Nevertheless, couples adapt to this transition, gradually accepting and reducing the intensity with which they miss their children (Kaur & Kaur, 2021). Also worth noting in this study is the *supportive relationship between parents and adult children*. As described by Relvas (1996), the appreciation of interdependence allows sharing difficulties, advice, and experiences and providing assistance at crucial moments in the lives of both. Couples/parents also maintain *financial support* for their children, constituting a significant source of help (Camarano, 2020). The creation of a space with relationship reciprocity, relationship enrichment versus feelings of abandonment (Relvas, 1996), occurs when the family system opens to grandchildren, sons- and daughters-in-law, and their *integration into the family*, as confirmed by the couples under study.

The pandemic context caused the participants to feel sad and dissatisfied, which Silva et al. (2020) and Carmo et al. (2020) also observed. Nevertheless, it did not cause maladjustments in the parent-child relationship. Families found new ways to adapt, mainly through new technologies, as did other families in the same situation (Bung et al., 2020). The *satisfaction with the contact* and quality of the relationship with their children expressed by couples can protect them from the empty nest syndrome. Over time, the couples' feelings of missing their children give way to adaptation through some level of connection between them (Kaur & Kaur, 2021).

While caring for the well-being and autonomy of their children, empty nest couples face increased responsibilities associated with the frailty, illness, or disability of their parents or spouse. One of the family members' illness may represent a threat to functioning, implying an adjustment in the reorganization process of the family's structure, roles, and emotional relationships (Cunha et al., 2018). Female participants demonstrated greater *family coping* skills, which is justified by the cultural association of the caregiver's role with women.

Couples use *spiritual beliefs and values* as forms of acceptance that help minimize the impact of adverse, stress-generating events. As mentioned in previous studies (Figueiredo, 2012; Kraus et al., 2021), these beliefs and values incorporate hope and lived experiences and relate to the search for meaning regarding life events and family continuity as a shared objective and project.

The *beliefs about the health professionals' intervention* highlighted the nurses' role as resource mobilizers and promoters of the potential of the individual and marital subsystems. These professionals were considered guides in the couples' decision-making. The recognition of the role of Family Health nurses as facilitators of access to health care and their scientific skills (Figueiredo, 2012) emerges in this study as the appreciation and social acknowledgment of these health professionals' role.

The schematic representation of the results obtained (Figure 6) illustrates a balanced family system, with permeable boundaries with the outside, in harmony with the marital and parental subsystems at the levels of development and functioning. Balance is achieved by interconnecting all areas of attention, operational dimensions and categories, and their influence on each other.

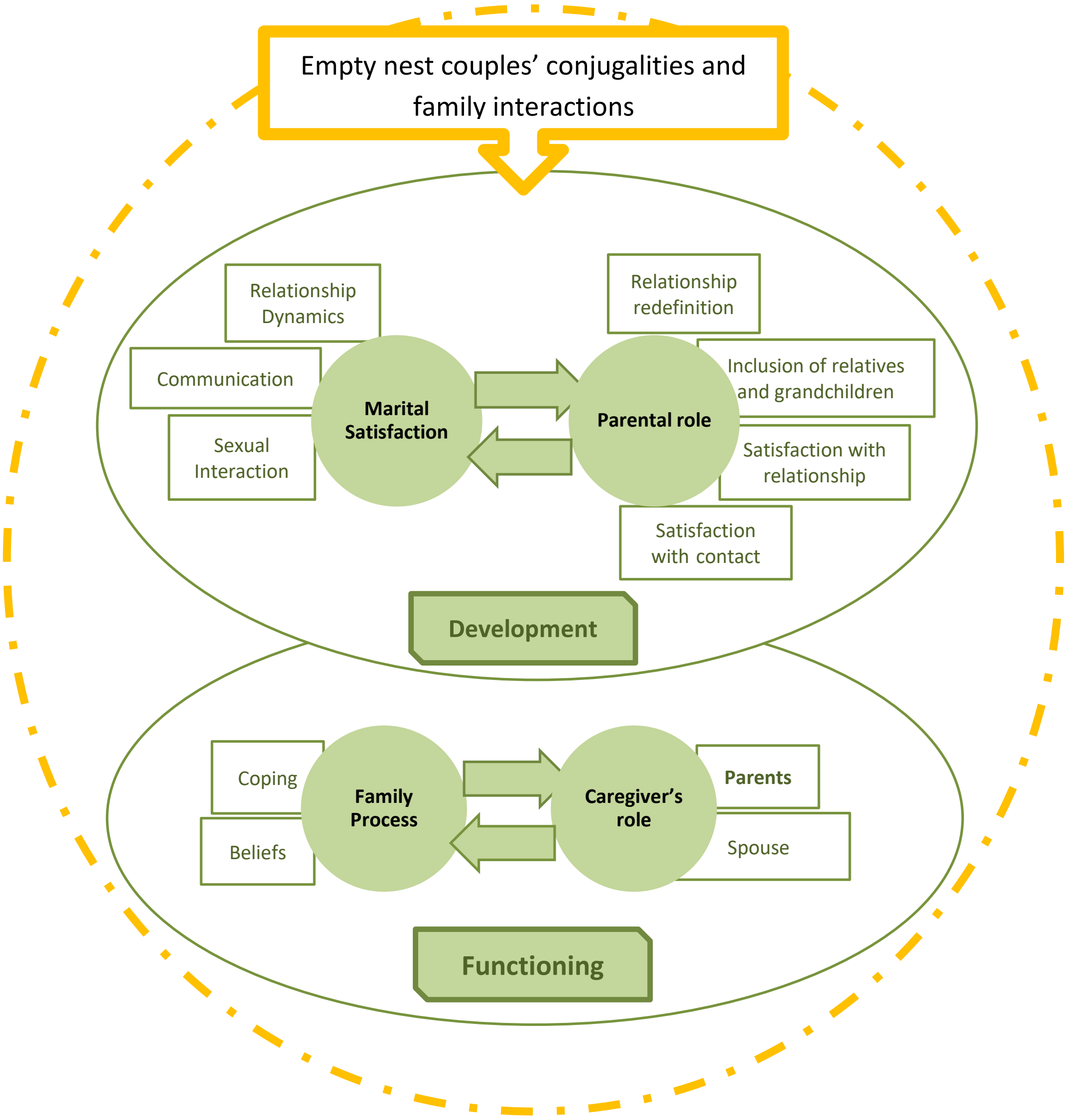

Figure 6 - Schematic representation of the results

CONCLUSION

Couples in the empty nest phase revealed satisfaction with their conjugality and the interaction maintained with their children, relatives by affinity, and grandchildren. Their differences in communication were overcome and did not harm marital development. The spouses demonstrated affection and sexual expression differences that they considered not to be a problem. They reported a mix of feelings caused by the children's departure and gradually adapted to the inherent changes. The coping skills seemed efficient, with female participants demonstrating a greater need for facilitating adaptation resources. The Family Health nurse's importance as a facilitator of this adaptation process was recognized.

The MDAIF allowed analyzing the results and understanding the couples' perspectives on their empty nest conjugality, the development and functioning of families, the couples' adaptation to their adult children's departure, and the resources that facilitated this adaptation.

Not using the MDAIF as an initial guide for gathering information limited a more comprehensive analysis.

This study's empty nest couples expressed overall satisfaction with this phase of their family life cycle, and their perspectives were incompatible with the empty nest syndrome. It was also clear that the Family Health Nurses' investment in conjugality and parenthood are protective factors and should be used as strategies to empower couples, integrating anticipatory care in nursing consultations.

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CONJUGALIDADES E INTERAÇÕES FAMILIARES DE CASAIS EM “NINHO VAZIO”: ANÁLISE BASEADA NO MODELO DINÂMICO DE AVALIAÇÃO E INTERVENÇÃO FAMILIAR

EMPTY NEST COUPLES’ CONJUGALITIES AND FAMILY INTERACTIONS: ANALYSIS BASED ON THE DYNAMIC MODEL OF FAMILY ASSESSMENT AND INTERVENTION

CONYUGALIDADES E INTERACCIONES FAMILIARES DE PAREJAS EN “NIDO VACÍO”: ANÁLISIS BASADA EN EL MODELO DINÁMICO DE EVALUACIÓN E INTERVENCIÓN FAMILIAR

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RESUMO

Introdução: A etapa do ciclo de vida das famílias em que os filhos adultos saem de casa, expressa-se por alterações na dinâmica das famílias, implicando reorganização conjugal e redefinição das relações entre pais e filhos.
Objetivo: Analisar a perceção de casais sobre a sua conjugalidade em “ninho vazio”; analisar o desenvolvimento de casais e a funcionalidade de famílias em “ninho vazio”; descrever a adaptação dos casais à saída dos filhos adultos de casa; analisar os recursos que facilitaram a adaptação dos casais a esta fase.
Métodos: Estudo descritivo exploratório de abordagem qualitativa. Participaram oito casais heterossexuais em “ninho vazio” (N = 16). Amostra recolhida por “bola de neve”. Utilizada entrevista semiestruturada para recolha da informação. Tratamento e análise dos dados realizados através da análise de conteúdo de Bardin, com categorias baseadas no Modelo Dinâmico de Avaliação e Intervenção Familiar.
Resultados: Os casais adaptam-se gradualmente às alterações inerentes à saída dos filhos de casa. Mostram-se satisfeitos com a conjugalidade e com a interação mantida com os filhos. As divergências comunicacionais são ultrapassadas, não prejudicando o desenvolvimento conjugal. As estratégias de coping foram eficazes. Nas mulheres, nota-se maior necessidade na dedicação a interesses e atividades lúdicas e de lazer.
Conclusão: Os casais estão satisfeitos com a sua conjugalidade, adaptaram-se bem à saída dos filhos e abriram-se à família. O enfermeiro de saúde familiar foi reconhecido como recurso facilitador deste processo de adaptação.

Palavras-chave: “Relação marital”; “ninho vazio”; “enfermagem familiar”; “satisfação conjugal”; “Modelo de Avaliação e Intervenção Familiar”

ABSTRACT

Introduction: Changes in family dynamics mark the phase in the family life cycle when adult children leave home. These changes involve marital reorganization and redefining the relationships between parents and children.
Objective: To explore couples’ perspectives on their empty nest conjugality, analyze couples’ development and empty nest families’ functioning, describe couples’ adaptation to their adult children’s departure, and examine the resources facilitating couples’ adaptation to this phase.
Methods: This is a descriptive exploratory study with a qualitative approach. The sample, recruited using the snowball method, consisted of eight heterosexual empty nest couples (N = 16). Information was collected using semi-structured interviews. The data were treated and analyzed using Bardin’s content analysis, with categories based on the Dynamic Model of Evaluation and Family Intervention.
Results: The couples gradually adapted to the changes caused by their children’s departure. They were satisfied with their conjugality and the interaction maintained with their children. Communication differences were overcome and did not harm the marital development. The coping strategies were effective. Female participants showed a greater need to dedicate themselves to interests and recreational and leisure activities.
Conclusion: The couples were satisfied with their conjugality, adapted well to their children’s departure, and opened to the family. The Family Health nurse was recognized as a facilitating agent in this adaptation process.

Keywords: “Marital relationship“; “empty nest”; “family nursing”; “marital satisfaction”; “Model of Family Assessment and Intervention”

RESUMEN

Introducción: La etapa del ciclo de vida de las familias en que los hijos adultos dejan el hogar se expresa por cambios en la dinámica familiar, lo que implica reorganización conyugal y redefinición de las relaciones entre padres e hijos.
Objetivo: Analizar la percepción de las parejas sobre su conyugalidad en el “nido vacío”; analizar el desarrollo de las parejas y la funcionalidad de las familias en el “nido vacío”; describir la adaptación de las parejas cuando sus hijos adultos salir del hogar; analizar los recursos que facilitaron la adaptación de las parejas en esta fase.
Métodos: Estudio exploratorio descriptivo con abordaje cualitativa. Participaron ocho parejas heterosexuales en “nido vacío” (N = 16). Muestra recolectada por “bola de nieve”. Para la recolección de la información se utilizó la entrevista semiestructurada. Procesamiento y análisis de datos realizado a través del análisis de contenido de Bardin, con categorías basadas en el Modelo Dinámico de Evaluación e Intervención Familiar.
Resultados: Las parejas se adaptan gradualmente a los cambios inherentes a la salida de sus hijos del hogar. Están satisfechos con la conyugalidad y con la interacción mantenida con los hijos. Se superan las divergencias comunicacionales, no perjudicando el desarrollo conyugal. Las estrategias de afrontamiento fueron efectivas. En las mujeres existe una mayor necesidad de dedicación a intereses y actividades lúdicas y de ocio.
Conclusion: Las parejas están satisfechas con su conyugalidad, se han adaptado bien a la partida de sus hijos y se han abierto a la familia. Lo enfermero de salud de la familia fue reconocido como un recurso que facilita ese proceso de adaptación.

Palabras Clave: “Relacion matrimonial”; “ninho vazio”; “Enfermería de la Familia”; “satisfacción conyugal”; “Modelo Dinámico de Evaluación e Intervención Familiar”

INTRODUÇÃO

Família é um sistema dinâmico, que evolui ao longo do tempo, onde existem laços ou relações e onde cada membro tem papéis e funções. É a primeira instituição para a socialização e desenvolvimento individual, apresentando como funções primordiais o apoio e proteção aos seus membros e a formação do papel familiar da pessoa (Relvas, 1996). De acordo com Wrigth & Leahey (2013), a família pode ser definida por quem os seus membros dizem que são, enfatizando o respeito pelos relacionamentos significativos e tornando-se pertinente na abordagem sistémica do cuidado à família.

A etapa do ciclo vital familiar caracterizada pela saída dos filhos adultos de casa, também conhecida por ninho vazio, traz novas tarefas para os elementos da família, podendo surgir dificuldades e novas necessidades relacionadas com a reestruturação do desenvolvimento da conjugalidade e com as interações familiares. Neste sentido, a conjugalidade traduz-se num desafio para os casais, uma vez que, com a saída dos filhos de casa torna-se necessária uma revisão das prioridades do casal voltando a focar-se na conjugalidade.

A unidade familiar e as suas respostas às transições são alvo dos cuidados da Enfermagem de Saúde Familiar. A capacitação das famílias para o desenvolvimento de aptidões que permitam a sua adaptação aos processos de mudança constitui-se como importante foco desta área da Enfermagem. Assim, ao analisar famílias em ninho vazio, sob o ponto de vista de desenvolvimento e funcional, é possível compreender a sua trajetória, para a concretização de cuidados antecipatórios relativos ao desenvolvimento de tarefas essenciais, previstas para cada etapa, e preparar a família para futuras transições (Figueiredo, 2012). O enfermeiro especialista em Enfermagem Comunitária, na área de Enfermagem de Saúde Familiar considera “… a família como unidade de cuidados, promove a sua capacitação focando-se na família como um todo e nos seus membros individualmente ao longo do ciclo vital e nas suas transições.” (Ordem dos Enfermeiros, 2018, p. 19357). Nas suas competências específicas, e no sentido de facilitar as respostas familiares em casos de transição complexa, incluem-se a análise da dinâmica familiar com identificação das suas dificuldades, das suas forças e do seu potencial de crescimento perante a mudança; a promoção do processo de consciencialização da família sobre estes aspetos; a exploração de estratégias e recursos com vista a melhorar a dinâmica familiar; e a promoção de relações de apoio mais adequadas (Ordem dos Enfermeiros, 2018).

A finalidade deste estudo é contribuir para a qualidade das práticas de enfermagem nesta fase de transição do ciclo vital familiar. Foi colocada a questão de investigação “Qual a perceção de casais em “ninho vazio” sobre a sua conjugalidade e as suas interações familiares?” e formularam-se os seguintes objetivos: analisar a perceção de casais sobre a sua conjugalidade em “ninho vazio”; analisar o desenvolvimento de casais e a funcionalidade de famílias em “ninho vazio”; descrever a adaptação dos casais à saída dos filhos adultos de casa; analisar os recursos que facilitaram a adaptação dos casais nesta fase.

1. ENQUADRAMENTO TEÓRICO

A fase do ciclo vital da família em que os filhos adultos deixam a casa dos seus pais designa-se “família com filhos adultos” (Relvas, 1996), “lançando os filhos e seguindo em frente” (Carter & McGoldrik, 1995) ou “ninho vazio”. Esta fase caracteriza-se pelo reconhecimento do estado adulto e independência dos filhos, ocasionando uma dualidade de sentimentos e exigindo renovação da conjugalidade (Thapa et al., 2018).

A designação “ninho vazio” não é consensual. A sua conceptualização, com origem nos anos 30, comportou uma dimensão depressiva da vida familiar, pouco favorável à sua necessária reestruturação (Relvas, 1996). Contudo, esta terminologia enraizou-se na literatura e o ninho vazio é hoje discutido em duas vertentes, uma patológica, associada a um estado depressivo, e outra positiva, transformadora, de renovação da vida conjugal.

Na vertente patológica, a síndroma do ninho vazio é a condição psicológica que afeta ambos os pais quando os filhos saem de casa, caracterizada pela vivencia de sentimentos de luto, perda, medo, incapacidade, dificuldade de ajuste aos novos papéis e mudança das relações parentais (Bougea et.al., 2019). Esta pode ser, portanto, uma fase emocionalmente difícil, com sentimentos de tristeza, solidão e inseguranças para os pais, pois a independência de um filho pode criar uma alteração na sua vida (Kaur & Kaur, 2021).

Pelo contrário, o ninho vazio, na sua vertente transformadora, pode ser emocionante para o casal tornando-se uma transição enriquecedora, produtiva e criativa, reavivando o relacionamento com o parceiro. É uma oportunidade de reconexão, um tempo de renovação de velhas amizades, hobbies, um reacender interesses, crescimento pessoal contínuo, autoaceitação e melhor qualidade de vida (Bougea et al., 2019; Fonseca et al., 2022; Kaur & Kaur, 2021).

A perceção da mudança dos filhos, como uma nova aventura para o desenvolvimento, e não uma perda, ajudará os pais a trabalhar a ausência do(s) filho(s) de sua casa, e a aprender a lidar com o vazio associado à chamada síndrome do ninho vazio (Kaur & Kaur, 2021). No entanto, grandes desafios são colocados à capacidade de retomar e/ou renovar a intimidade conjugal, eventualmente ofuscada pelo papel parental e perdida ao longo dos anos (Thapa et al., 2018).

A satisfação conjugal relaciona-se com a estabilidade da relação, com estratégias para gerir diferenças, qualidade das interações quotidianas e respeito, admiração e gratidão pelo cônjuge, favorecendo a aceitação, a valorização e a confiança (Chaskelmann, 2020). Deste modo, os casais em “ninho vazio”, necessitam partilhar os seus sentimentos mais íntimos, apoiar-se mutuamente, cuidar física e emocionalmente do outro, para se reencontrarem na sua conjugalidade (Thapa et al., 2018).

No entanto, alguns estudos afirmam que não há alteração significativa na vida dos casais depois de os seus ninhos serem esvaziados (Fonseca et al., 2022).

Os enfermeiros, através das suas intervenções terapêuticas, ajudam a família a desenvolver padrões de interação adequados às mudanças vivenciadas ao longo do ciclo vital familiar, e a adotarem estratégias de *coping* mais eficientes e efetivas. Ao Enfermeiro Especialista em Enfermagem Comunitária na área da Saúde Familiar compete realizar intervenções promotoras da capacitação dos casais para lidarem com os desafios das transições do ciclo vital familiar, reduzindo os impactos negativos destas.

O Modelo Dinâmico de Avaliação e Intervenção Familiar (MDAIF) é um modelo interativo e flexível, de abordagem multidimensional, centrado nas interações familiares e na complexidade do sistema familiar. Permite identificar as necessidades e recursos das famílias, estabelecer prioridades, planear intervenções e executá-las. Estimula a participação das famílias em todo o processo a encontrarem soluções promotoras de mudança e restabelecimento saudável do funcionamento familiar, objetivando o fortalecimento da unidade familiar (Figueiredo, 2012). A figura 1 ilustra o modelo e as suas três dimensões avaliativas, fundamentais e relevantes na prática de cuidados de enfermagem às famílias.

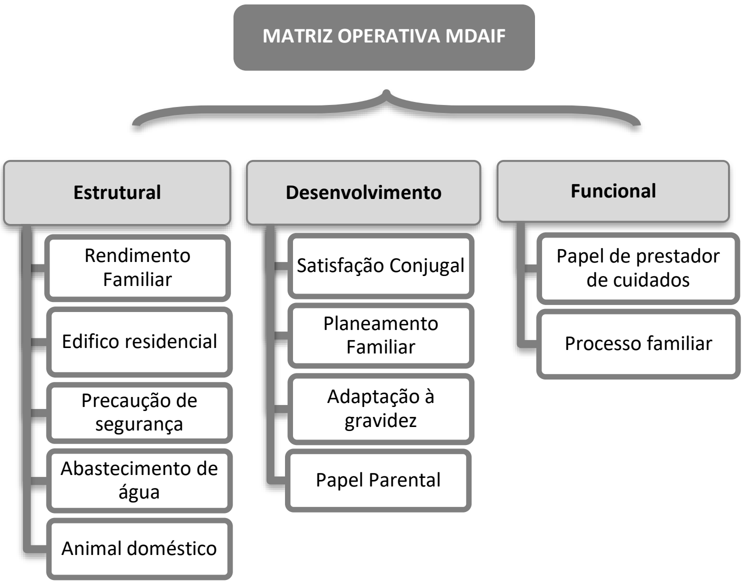

Figura 1 - Áreas de intervenção por domínios avaliativos

Os estudos sobre intervenções de enfermagem facilitadoras desta transição no ciclo vital familiar, que ocorre com a saída dos filhos, são escassos, tornando-se essencial conhecer o desenvolvimento e a funcionalidade das famílias para fundamentar as intervenções do enfermeiro de família.

2. MÉTODOS

2.1 Amostra

Estudo qualitativo descritivo-exploratório. Participaram 16 sujeitos que constituem 8 casais em fase de “ninho vazio”. A amostra foi intencional, obtida pela técnica de amostragem em “bola de neve” (Coutinho, 2022), recolhida até ser atingida a saturação da informação. Constituíram critérios de inclusão: casais heterossexuais com filhos, casados ou em união de facto, em ninho vazio há mais de seis meses. Os critérios de exclusão foram: casais com pelo menos um filho em casa.

Os princípios éticos foram cumpridos. Estudo aprovado pela Comissão de Ética da Unidade de Investigação em Ciências da Saúde (n.º 704/ 09-2020).

2.2 Instrumentos de recolha de dados

O instrumento de recolha de informação foi a entrevista semiestruturada, com 4 questões abertas e 1 de caraterização sociodemográfica, elaboradas através de guião. Estas questões foram complementadas no decorrer da entrevista, conferindo flexibilidade e recolha mais livre e não padronizada das informações (Coutinho, 2022). As entrevistas, efetuadas com recurso a gravador áudio, realizaram-se individualmente, para evitar constrangimentos nas respostas, e por opção dos casais ocorreram no domicílio, entre dezembro de 2020 e fevereiro de 2021, respeitando-se as recomendações relativas às medidas preventivas da

COVID-19. As entrevistas foram transcritas integralmente e realizada a análise de conteúdo (Bardin, 2018). Na transcrição, respeitou-se a linguagem dos participantes e utilizaram-se algumas convenções, para registar comentários, interpolações, pausas e silêncios.

2.3 Análise de dados

Para a análise da informação, utilizou-se o MDAIF (Figueiredo, 2012) analisando e agregando em áreas de atenção, dimensões operativas, categorias, subcategorias e unidades de registo, tendo em conta semelhanças e convergência temática do conteúdo dos textos, chegando aos resultados e permitindo a sua discussão.

As particularidades do modelo, aliadas ao caráter dinâmico, flexível, colaborativo e interativo, tornam-no importante para conhecer, avaliar, compreender e cuidar das famílias enquanto unidade de cuidados, no âmbito dos CSP e da Enfermagem de Saúde Familiar, e justificam a escolha relativamente a este quadro teórico.

A validação da análise foi realizada por dois juízes externos à investigação, peritos no sistema de categorização, acrescentando rigor à investigação.

3. RESULTADOS

Atendendo ao MDAIF (Figueiredo, 2012), inicia-se a apresentação dos resultados pela *Dimensão Estrutural*, identificando-se a composição familiar, o tipo de família e a família extensa.

Participaram no estudo 8 casais heterossexuais que constituem o agregado familiar, casados ou em união de facto, entre 32 e 50 anos. A média de idades das mulheres é 61,9 anos e dos homens é 66,3 anos. Destes casais, 50% tem 1 filho e 50% tem 2 filhos, biológicos. Um dos casais com 2 filhos, tem um filho falecido. Os casais estão há 8,1 anos, em média, em ninho vazio (entre 15 meses e 14 anos).

Segue-se a apresentação das dimensões de desenvolvimento e funcional, através das áreas de atenção, dimensões operativas, categorias, subcategorias e unidades de registo. A *Dimensão de Desenvolvimento* possibilita o entendimento dos fenómenos relacionados com o crescimento e com a evolução da família no seu percurso de vida (Figueiredo, 2012). Nesta dimensão identificaram-se as áreas de atenção *Satisfação Conjugal* e *Papel Parental,* conforme a figura 2.

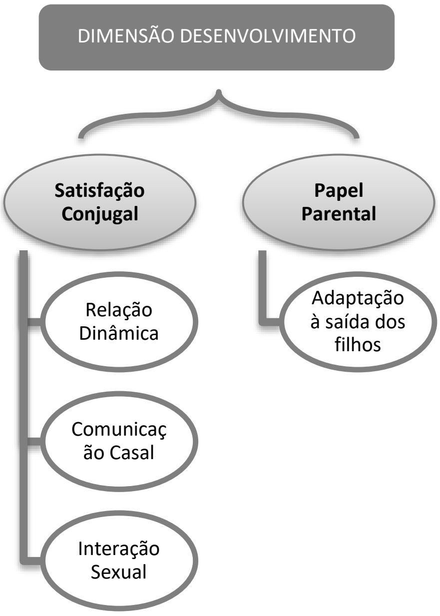

Figura 2. Áreas de Atenção e Dimensões Operativas da Dimensão de Desenvolvimento

A *Satisfação Conjugal* centra-se nos processos de conjugalidade associados à continuidade de uma relação satisfatória, percecionada como apoiante das várias vertentes que se interligam (Figueiredo, 2012). Nesta, os discursos dos participantes orientaram-se para as dimensões operativas*: Relação Dinâmica, Comunicação e Interação Sexual*, não tendo existido narrativas relativas à função sexual, como ilustra a figura 3.

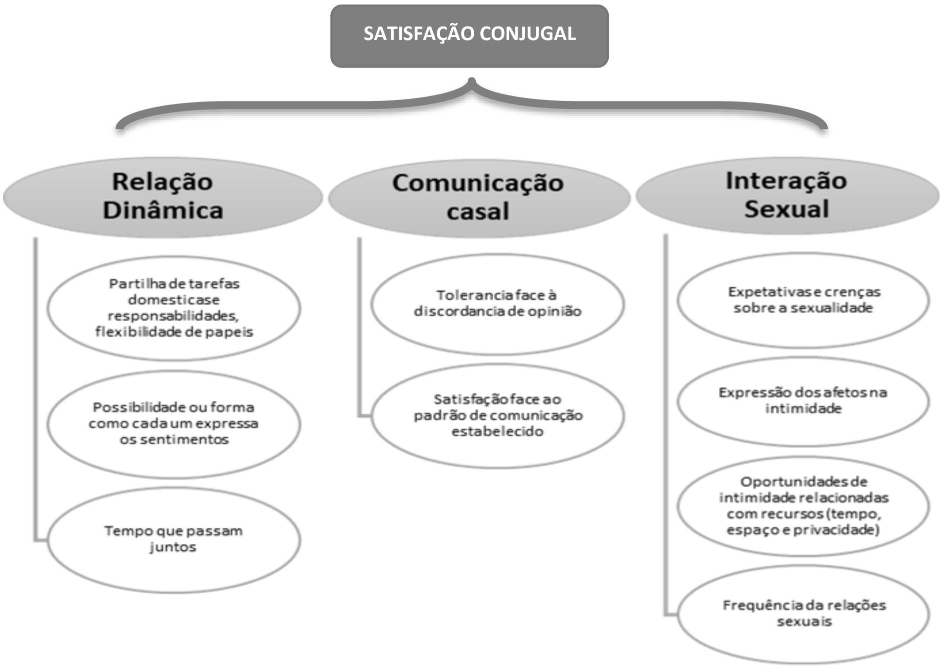

Figura 3 - Dimensões Operativas da Área de Atenção Satisfação Conjugal

A dimensão operativa *Relação Dinâmica,* na categoria *Partilha de tarefas domésticas e responsabilidades, e flexibilidade de papéis***,** mostra a reorganização dos casais após a saída dos filhos: *“Sim, aliás eu partilho mais tarefas agora do que antes.”* (H2); ou manutenção das rotinas e responsabilidades diárias: *“Já eram repartidas as tarefas … as nossas rotinas continuaram na mesma”* (H4).

Na *Possibilidade ou forma como cada um expressa os seus sentimentos acerca do cônjuge*, nota-se evidência dos aspetos favoráveis: *“Estamos só os dois … estamos mais unidos…”* (M5); e *“A nossa palavra é união (…) há sempre ali aquele vazio e temos de ser cada vez mais unidos.”* (H4).

O *Tempo que passam juntos*, após a saída dos filhos, foi gerador de satisfação. Os casais referem: *“Temos mais tempo, eu para ele e ele para mim.”* (M5), para os interesses comuns e atividades conjuntas: *“(…) caminhadas e passeios, tudo com ele, em conjunto.”* (M2). Contudo, existem narrativas que não demonstram total satisfação, embora não prejudicando a relação dinâmica do casal: *“É certo que ela às vezes … foge mais do que eu em função daquilo que eu gostava… Se calhar gostava até de passear, mas ela é mais … caseira.”* (H7).

Ainda relativamente a esta categoria, o momento pandémico teve repercussões na conjugalidade dos participantes, obrigando a mais realização de atividades em casa, ou na sua periferia, e menos em socialização: *“… normalmente quando eu ia às compras ia sempre mais ele, agora com o covid não. Normalmente ele não quer ir, mais por causa da pandemia(...)”* (M6).

Na dimensão operativa *Comunicação do Casal*, foi identificada a categoria *Tolerância face à discordância de opinião*: *“… é certo que às vezes há uma discordância um com o outro, mas isso é sanável, a maior parte dos casais tem essas coisas...”* (H7).

A categoria *Satisfação face ao padrão de comunicação estabelecida*, foi identificada nos relatos de alguns participantes: *“… hoje, olhando à situação, certamente estamos mais perto um do outro, falamos muito mais …”* (H7). Essa satisfação não é comum a todos, pois alguns participantes referem alterações relacionadas com a falta de diálogo: *“Às vezes acho que não falamos o suficiente, fugimos às vezes a certas situações e contornamo-las (…) para que não haja choques.”* (H6).

A dimensão operativa *Interação Sexual,* concetualizada como atributos relacionais que integram valores e atitudes conducentes à expressão da sexualidade (Figueiredo, 2012), foi ilustrada com quatro categorias que em seguida se apresenta.

Nas *Expetativas e crenças sobre a sexualidade*, num dos casais constaram-se diferenças relativamente à sexualidade, atribuídas à falta de afeto da família de origem do cônjuge: *“… não sei se não tem a ver com a maneira como ele foi criado (…) os pais dele eram umas pessoas muito frias e nunca souberam dar amor e eu fui criada pobre, mas com muito amor (…)”* (M7).

Na *Expressão dos afetos na intimidade*, as narrativas evidenciaram participantes satisfeitos, referindo: *“… em termos de intimidade acho que houve uma outra abertura (…) Há uma certa proximidade…”* (H6). Porém, outros relatos revelaram que a intimidade entre os cônjuges ficou menos expressiva: *“Na questão afetiva é que quebrou um bocado (…) não só por ela, mas também por mim (…)”* (H3).

Relativamente às *Oportunidades de intimidade relacionadas com recursos associados ao tempo, espaço e privacidade,* a análise mostrou divergências de opinião entre cônjuges. As mulheres negam mudanças: *“Em termos de tempo, vontade, troca de* *carícias?... Não, acho que não, não mudou nada.”* (M6). Os homens afirmam a melhoria no relacionamento íntimo: *“Mudou (…) temos mais liberdade prontos, estamos mais à vontade…”* (H6).

Por fim, a *Frequência das relações sexuais* é influenciada por aspetos inerentes a cada cônjuge, não atribuída diretamente à saída dos filhos: *“Em termos de vida conjugal tem mais a ver com a própria disposição do casal (…) as alterações que pode haver é também com a idade, com a disposição, com o cansaço... Não é a saída dos filhos.”* (M2).

Ainda na dimensão de desenvolvimento, a área de atenção *Papel Parental* define-se pelos papeis familiares caraterizados pelos padrões comportamentais dos elementos da família em relação às expectativas e crenças face ao papel resultante do modelo funcional do sistema, e dos fatores culturais a ele subjacente (Figueiredo, 2012). A análise de conteúdo revelou narrativas apenas na dimensão operativa *Adaptação da família à saída dos filhos de casa,* e suas categorias, tal como se apresenta na figura 4.

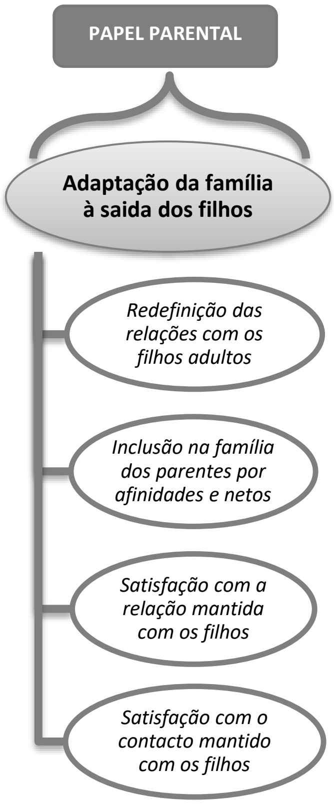

Figura 4 - Dimensão Operativa e Categorias da Área de Atenção Papel Parental

Na *Redefinição das relações com os filhos adultos*, encontram-se várias fases constatando-se diferenciação face ao relato do momento de transição. A fase imediata à saída dos filhos parece ter sido vivenciada como “*Ninho Vazio*”. Todavia, com o passar do tempo, essas sensações foram sendo ultrapassadas, revelando uma adaptação equilibrada: *“Senti saudade sim, saudade, tristeza, um bocado de nostalgia, ficarmos assim sozinhos… mas depois com o tempo tudo se vai …”* (H5).

Duas subcategorias foram identificadas. O *Suporte económico aos filhos,* cuja saída de casa implica, por vezes, o aumento da despesa dos pais ao ajudarem financeiramente e na compra de bens essenciais: *“… nós damos perto de 500 euros todos os meses para ela (…)”* (H3). A *Relação de ajuda entre pais e filhos adultos*, onde é notada reciprocidade relacional, preocupação com o bem-estar e ajuda mútua, indicando que a adaptação a esta etapa foi alcançada gradualmente, com equilíbrio na redefinição de papéis: *“… então os pais estão cá para ajudar naquilo que é preciso e depois também contamos com eles.”* (H4) e *“Se houver problemas da parte dele, chama-nos (…) se nós tivermos problemas, chamamo-lo a ele, e ele corresponde à nossa chamada, nós fazemos a mesma coisa (…)”* (H8).

Na categoria *Inclusão na família dos parentes por afinidades e netos,* a análise revelou que todos são bem acolhidos e aceites pelo casal, facilitando a criação de vínculos interacionais entre todos: *“O R. é outro filho mesmo (…) ele é uma mais-valia.” (M5)* e *“Vêm aqui com os miúdos e andamos sempre por aqui a brincar (…). Temos três netos, dois gémeos e uma menina…”* (H5).

A categoria *Satisfação com a relação mantida com os filhos* foi evidente, mesmo nas famílias com filhos geograficamente distantes: *“… mesmo longe está sempre presente. Tanto que no dia em que eu rapei o meu cabelo ele rapou o cabelo dele, lá! E a falar comigo pelo Facebook.”* (M1); “*Continuam os laços, não se cortaram os vínculos, antes pelo contrário*…” (H7).

Uma categoria identificada e muito valorizada foi a *Satisfação com o contacto mantido com os filhos*, pois ameniza o vazio sentido pela ausência e tranquiliza ao comprovar que estão bem: "*Muito importante (…) a maneira como eles respondem ou a maneira como eu os vejo através da videochamada eu sei como é que eles estão (…) Falando com eles, ouvindo a voz, vejo logo se estão bem ou não.*" (M6).

Nesta categoria surge as *Alterações no contacto com os filhos devido à pandemia*. Para alguns casais esta situação pandémica atrasou o reencontro com os filhos emigrados, para outros, impediu as visitas mútuas, o convívio e a realização de atividades em conjunto: "*…mas se não fosse isso do Covid ele já cá estava, já tinha tudo tratado para vir em junho só que depois isto atrasou tudo…*" (M1).

Apresenta-se, em seguida, a *Dimensão Funcional.* Esta refere-se aos níveis de "*… interação familiar que permitem o desempenho das funções e tarefas familiares a partir da complementaridade funcional que dá sustentabilidade ao sistema e, dos valores que possibilitam a concretização das suas finalidades, pelos processos co-evolutivos que permitem a continuidade*." (Figueiredo, 2012). Como mostra a figura 5, as áreas de atenção identificadas nesta dimensão foram: *Papel de Prestador de Cuidados e Processo Familiar.*

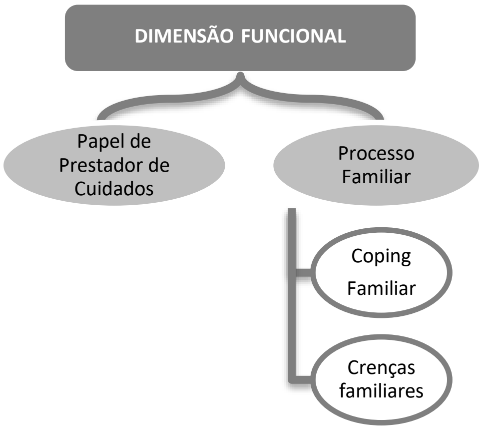

Figura 5 - Áreas de Atenção e Dimensões Operativas da Dimensão Funcional

O *Papel de Prestador de Cuidados,* representa um acréscimo de responsabilidades com a dependência dos pais idosos e consequente necessidade de cuidados, e a doença de um dos cônjuges. O envelhecimento e a dependência são questões importantes e desafios para as gerações mais novas, quando têm os pais ao seu cuidado: "*Tive a minha mãe doente, o meu pai ficou depois sozinho em casa e tínhamos que alternar (…) podia acontecer alguma coisa, não é? Precisavam de nós…*" (H4). A doença de um elemento do casal, ao interferir na capacidade funcional e de autocuidado, levou o cônjuge a prestar todo o apoio que dele era esperado e percebeu-se que este papel foi valorizado e reconhecido: "*Na doença ele ajudou-me, sem dúvida (…) Ele foi meu chauffeur, foi meu marido, foi meu enfermeiro, foi meu tudo*." (M3).

O *Processo Familiar* detém como dimensões operativas o *Coping familiar* e *Crenças familiares*. Acerca do *Coping familiar,* só as mulheres referiram necessidade de recursos facilitadores: *"Eu tinha o tempo ocupado (…) e tinha amigas sim (…) íamos ali tomar cafezinho, lanchar à pastelaria*." (M3). As *Crenças familiares*, evidenciaram *Crenças espirituais e de valores*, em que os participantes aceitaram a saída dos filhos de uma forma gradual e adaptativa, baseando-se na crença de que este é o percurso normal da vida: *"Os filhos só são nossos quando são pequeninos. (…) a vida é mesmo assim … os filhos não podem viver eternamente em casa, portanto os pais (…) têm que pensar que eles têm que se libertar*." (M7).

Surgiram, também, *Crenças sobre intervenção dos profissionais de saúde.* A maioria reconhece que o enfermeiro de família poderá apoiar na redefinição da sua conjugalidade, especificando que há sinais da existência de dificuldades adaptativas, aos quais o enfermeiro de família deverá estar atento para intervir: *"O enfermeiro (…) poderia (…) encaminhar-nos ao que deveríamos fazer para nos sentirmos melhor, aconselhar (…)"* (M8).

3. DISCUSSÃO

Nesta fase do ciclo vital da família, a *satisfação conjugal* traduz-se na redefinição de papéis, reconstrução do relacionamento e na continuidade das atividades diárias, sem mudanças significativas nas vidas dos casais, tal como referido por Costa (2018).

A convivência ao longo da conjugalidade, conduz à habituação e à rotina, requerendo ajuste nas perceções, expectativas e comportamentos face ao outro. A renúncia, doação, diálogo e flexibilidade, contribuem para o equilíbrio da dinâmica relacional e fortalecimento da relação conjugal, corroborando Porreca (2019) e Silva et al. (2017).

O *tempo dos casais* constituiu uma oportunidade para descobrirem novos interesses e atividades comuns como referido por outros autores (Costa, 2018). A fase pandémica e o confinamento limitaram estas atividades nos casais em estudo, mas, ao contrario de Silva et al. (2020), não houve repercussões negativas decorrentes da pandemia na conjugalidade dos casais. Alguns referiram ter-se aproximado, favorecendo o uso da criatividade e do bom humor para superar as adversidades. Esta aproximação na fase de ninho vazio tem sido descrita por diversos autores (Falcão et al., 2020; Kaur & Kaur, 2021) não permitindo afirmar que se deve apenas ao tempo de confinamento vivido.

Em relação ao padrão de *comunicação* estabelecida, os que se sentem mais próximos do cônjuge têm tendência a investir mais no relacionamento, proporcionando-lhe estabilidade, tal como notado por Chaskelmann (2020). E, perante situações de conflito, a melhor estratégia apontada pelos casais, tal como descrito noutros estudos (Silva et al., 2017), poderá passar por evitar o confronto e a exaltação de conflitos conjugais, mantendo silêncio e reflexão sobre si para, posteriormente, compreender o parceiro.

Relativamente à *interação sexual*, as crenças e as expectativas de cada um e a duração da relação conjugal possibilitaram a aceitação, adequação e compreensão de um, ou de ambos, à individualidade do outro, resultados que vão ao encontro de Porreca (2019). A expressão da afetividade e sexualidade, são vividas de acordo com a individualidade e o modelo conjugal coconstruído ao longo dos anos. De facto, as diferenças encontradas nas narrativas dos participantes podem ser consideradas funcionais numa relação conjugal, na medida em que os subsistemas individual e conjugal se articulam no seio de uma relação, permitindo o seu desenvolvimento (Silva et al., 2017).

As *oportunidades de intimidade*, relacionadas com recursos associados ao tempo, espaço e privacidade, deram lugar ao ajuste sexual e aceitação das mudanças físicas de cada um, contribuindo para aumentar a satisfação conjugal, nomeadamente a *frequência das relações sexuais* (Rocha & Fensterseifer, 2019). Contudo, nos casais em estudo, reproduzindo modelos tradicionais, as mulheres negam diferenças a este respeito e os homens referem maior satisfação com a disponibilidade atual e espaço para o casal.

O *papel parental*, muito específico desta fase do ciclo familiar, mostra-se controverso na *redefinição das relações com os filhos adultos,* uma vez que o orgulho nos filhos pela autonomia alcançada coexiste com preocupação e tristeza face à distância. Mas, em geral, os casais adaptam-se a esta transição, aceitando gradualmente e reduzindo a intensidade da saudade (Kaur & Kaur, 2021). É também, neste estudo, notória a *relação de ajuda entre pais e filhos adultos.* Como descrito por Relvas (1996), a valorização da interdependência, possibilita partilhas sobre dificuldades, conselhos e experiências e interajuda em momentos cruciais das vidas de ambos. Nomeadamente, os casais/pais mantêm *suporte económico aos filhos*, constituindo uma fonte de apoio importante (Camarano, 2020). A criação de um espaço onde se estabeleçam relações recíprocas, de enriquecimento relacional versus sentimento de abandono (Relvas, 1996), ocorre com abertura do sistema familiar aos netos, genros e noras, e a sua *inclusão na família,* o que foi também confirmado pelos casais em estudo.

O contexto pandémico, provocou tristeza e insatisfação nos participantes, também constatado por Silva et al. (2020) e Carmo et al. (2020), mas não causou desajustes na relação pais-filhos. As famílias encontraram novas formas de adaptação, particularmente através das novas tecnologias, tal como outras famílias em situação idêntica (Bung et al., 2020). A *satisfação com o contacto* e qualidade da relação com os filhos, manifestada pelos casais poderá funcionar como protetor da “síndrome do ninho vazio”. Com o tempo, a saudade dá lugar à adaptação, através de algum nível de conexão entre eles (Kaur & Kaur, 2021).

Enquanto se preocupam com o bem-estar e autonomia dos filhos, os casais em “ninho vazio” deparam-se com responsabilidades acrescidas associadas à debilidade, doença e/ou incapacidade dos pais ou do cônjuge. A presença de doença num dos elementos da família pode representar uma ameaça à funcionalidade, implicando um ajustamento no processo de reorganização na estrutura, nos papéis e nas relações afetivas da família (Cunha et al., 2018). As mulheres foram quem mais evidenciou *coping familiar*, culturalmente justificado pela associação ao feminino do papel de cuidadora.

As crenças espirituais e de valores, usadas pelos casais como forma de aceitação, ajudaram a minimizar o impacto de eventos negativos e geradores de stress. Estas incorporam a esperança e experiências vividas, associadas à procura de sentido para acontecimentos da vida e continuidade da família enquanto desígnio e projeto compartilhado, corroborando estudos anteriores (Figueiredo, 2012; Kraus et al., 2021).

As c*renças sobre intervenção dos profissionais de saúde* evidenciaram o papel do enfermeiro como mobilizador de recursos e reforço das potencialidades dos subsistemas individual e conjugal, considerando estes profissionais orientadores das suas tomadas de decisão. O reconhecimento do papel do enfermeiro de família, enquanto elemento facilitador do acesso aos cuidados de saúde e das suas competências científicas (Figueiredo, 2012), emerge neste estudo como valorização e reconhecimento social do seu papel.

O esquema representativo dos resultados obtidos (figura 6) ilustra o sistema familiar em equilíbrio, com fronteiras permeáveis com o exterior, em harmonia com os subsistemas conjugal e parental, a nível do desenvolvimento e da funcionalidade. Todas as áreas de atenção, dimensões operativas e categorias interligam-se e influenciam-se mutuamente, proporcionando este equilíbrio.

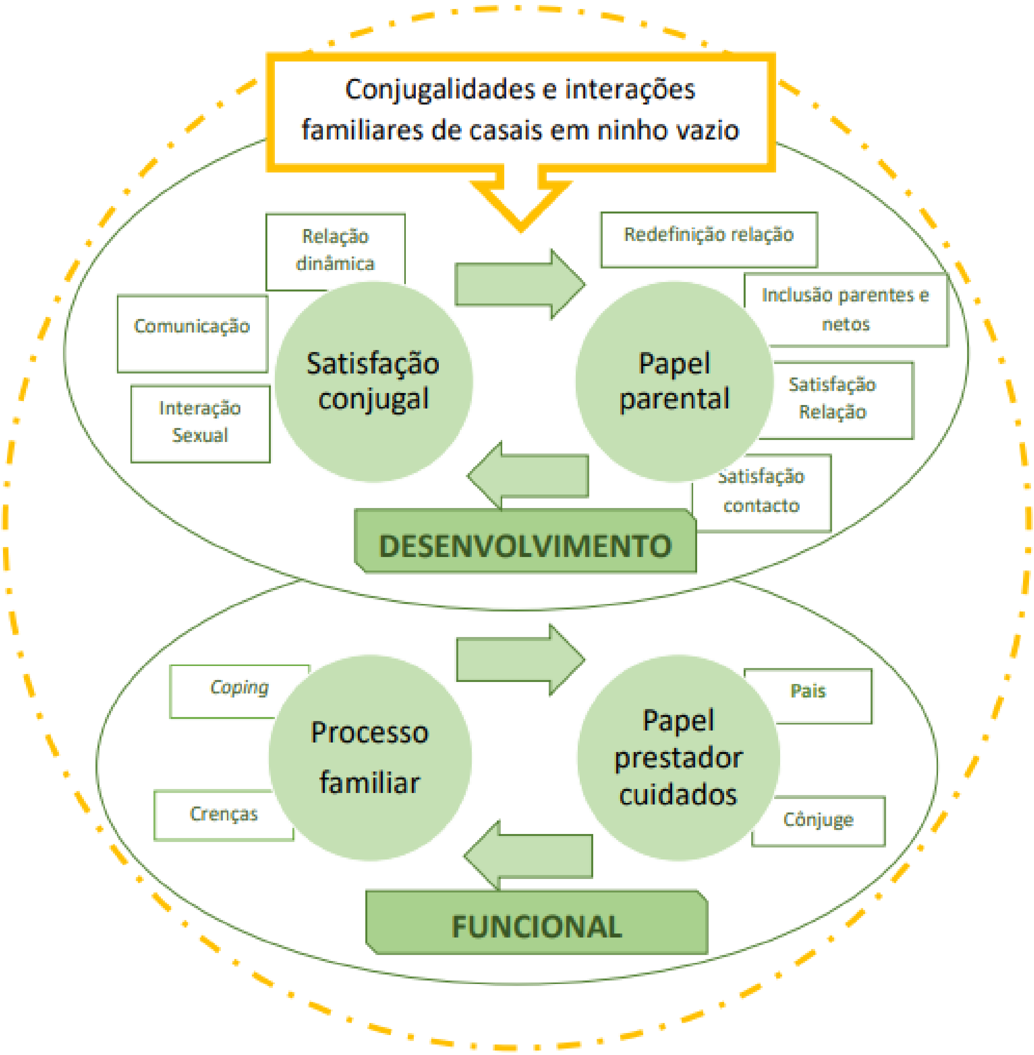

Figura 6 - Esquema representativo dos resultados obtidos

CONCLUSÃO

Os casais em fase de “ninho vazio” revelam satisfação com a conjugalidade e interação mantida com os filhos, parentes por afinidade e netos. As suas divergências comunicacionais são ultrapassadas, não prejudicando o desenvolvimento conjugal. Os cônjuges manifestam diferenças na expressão afetiva e sexual que consideram não ser um problema. Referem um misto de sensações com a saída dos filhos de casa e adaptaram-se gradualmente às alterações inerentes. O *coping* parece ter sido eficaz, notando-se maior necessidade de as mulheres recorrerem a recursos adaptativos facilitadores. É reconhecida a importância do enfermeiro de família como facilitador deste processo de adaptação.

O Modelo Dinâmico de Avaliação e Intervenção Familiar possibilitou a análise dos resultados, e permitiu compreender a perceção de casais sobre a sua conjugalidade em “ninho vazio”, o desenvolvimento e a funcionalidade de famílias, a adaptação dos casais à saída dos filhos adultos de casa e os recursos que facilitaram esta adaptação.

O facto de o Modelo referido não ter sido utilizado como guia inicial na recolha de informação constituiu limitação a uma análise mais abrangente.

Ficou evidente que estes casais em fase de “ninho vazio” manifestam satisfação global, não apresentando perceções compatíveis com síndrome de ninho vazio, percebendo-se que o investimento profissional na conjugalidade e na parentalidade são fatores protetores, devendo por isso ser utilizados como estratégias para capacitar os casais, integrando os cuidados antecipatórios, nas consultas de enfermagem.

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SATISFAÇÃO COM O TRATAMENTO E QUALIDADE DE VIDA EM ADOLESCENTES COM DM1 E SISTEMA DE PERFUSÃO SUBCUTÂNEA CONTINUA DE INSULINA

TREATMENT SATISFACTION AND QUALITY OF LIFE OF ADOLESCENTS WITH T1DM USING CONTINUOUS SUBCUTANEOUS INSULIN INFUSION

SATISFACCIÓN CON EL TRATAMIENTO Y CALIDAD DE VIDA EN ADOLESCENTES CON DMT1 MEDIANTE INFUSIÓN CONTINUA DE INSULINA SUBCUTÁNEA

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RESUMO

Introdução: O sistema de perfusão subcutânea contínua de insulina (PSCI) tem sido priorizado no controlo metabólico de crianças e jovens com Diabetes Mellitus tipo 1 (DM1).
Objetivo: Avaliar a qualidade de vida e a satisfação com o tratamento em adolescentes com DM1 que utilizam o sistema PSCI; Analisar o papel da qualidade de vida na predição da sua satisfação com o tratamento.
Métodos: Participaram 77 adolescentes, entre os 10 e os 18 anos. Utilizaram se dois questionários, um sobre Qualidade de vida associada ao tratamento com PSCI e outro sobre Satisfação com este tipo de tratamento.
Resultados: Os adolescentes tendem, maioritariamente a manifestar uma boa qualidade de vida, com valores mais baixos nas dimensões relativas ao Impacto da Diabetes, Sentimentos e Humor e Tempos Livres. Estão ainda satisfeitos com o sistema PSCI.. Através da regressão linear múltipla, testou-se um modelo de predição, tendo o Impacto da diabetes, os Tempos livres e os Sentimentos e humor explicado 32,7% da variância da Satisfação com o tratamento com PSCI.
Conclusão: O uso da PSCI é uma resposta terapêutica que os adolescentes com DM1 percebem como promotora da sua qualidade de vida e globalmente satisfatória, o que vai ao encontro da evidência. Porém, na promoção da adaptação à doença e regime terapêutico, aspetos como as implicações na autoimagem e a gestão emocional devem ser domínios de especial atenção.

Palavras-chave: diabetes do tipo 1; adolescentes; qualidade de vida; satisfação do paciente

ABSTRACT

Introduction: Continuous subcutaneous insulin infusion (CSII) has been prioritised in the metabolic control of type 1 Diabetes Mellitus (T1DM) in children and adolescents.
Objective: To assess the quality of life and treatment satisfaction in adolescents with T1DM using CSII and analyse the role of quality of life in predicting treatment satisfaction among these adolescents.
Methods: The sample comprised 77 adolescents aged 10 to 18, followed-up in two central hospitals in the Northern region of Portugal. The Quality-of-Life questionnaire for treatment with Insulin Infusion Pump – adolescents' version - and the adapted version for adolescents of treatment satisfaction with Insulin Pump questionnaire were used.
Results: Most adolescents reported a good quality of life, with lower values in the dimensions related to the Impact of Diabetes, Feelings and Mood and Leisure. They were satisfied with the CSII system, recognizing it as convenient, easy to use and guarantying autonomy. A prediction model was tested through multiple linear regression, with the Impact of diabetes, Leisure Time and Feelings and mood explaining 32.7% of the variance of treatment satisfaction.
Conclusion: CSII is a therapeutic option that adolescents with T1DM perceive to promote their quality of life and consider satisfactory, in line with the previous evidence. However, interventions aimed to support these adolescents in managing their disease and treatment should focus on aspects such as self-image and emotional well-being.

Keywords: type 1 diabetes; adolescents; quality of life; patient satisfaction

RESUMEN

Introducción: La infusión continua de insulina subcutánea (IICS) ha sido priorizada en el control metabólico de la Diabetes Mellitus tipo 1 (DM1) en niños y adolescentes.
Objetivo: Evaluar la calidad de vida y la satisfacción con el tratamiento en adolescentes con DM1 utilizando IICS, y analizar el papel de la calidad de vida en la predicción de la satisfacción con el tratamiento en estos adolescentes.
Métodos: Participaram 77 adolescentes, de 10 a 18 años, Se utilizó el cuestionario de Calidad de Vida para el tratamiento con IICS y el cuestionario de satisfacción del tratamiento con IICS.
Resultados: La mayoría de los adolescentes reportaron una buena calidad de vida, con valores más bajos en las dimensiones relacionadas con el Impacto de la Diabetes, sentimientos y Estado de Ánimo y Ocio. Están satisfechos con el sistema IICS. A través de la regresión lineal múltiple, se probó un modelo de predicción, con el Impacto de la diabetes, el Tiempo de Ocio y los Sentimientos y el estado de ánimo explicando el 32,7% de la varianza de la satisfacción con el tratamiento.
Conclusión: La IICS es una opción terapéutica que los adolescentes con DM1 perciben como promotora de su calidad de vida y se sienten como satisfactoria, en línea con la evidencia previa. Sin embargo, las intervenciones dirigidas a apoyar a estos adolescentes para manejar su enfermedad y tratamiento deben centrarse en aspectos como la autoimagen y el bienestar emocional.

Palabras Clave: diabetes do tipo 1; adolescentes; calidad de vida; satisfacción del paciente

INTRODUCTION

Type 1 diabetes mellitus (T1DM) is one of the most common chronic pathologies worldwide, with increasing incidence rates. According to the International Diabetes Federation, approximately 1.1 million children and young people suffer from this disease (Patterson et al., 2019). In Europe, there is also an increasing trend of about 3.4%, and it is estimated to double within 20 years (Patterson et al., 2019). In Portugal, 2015, according to the Observatório Nacional da Diabetes [National Observatory for Diabetes] (Observatório da diabetes 2016), a total of 3,327 individuals aged 0-19 years were diagnosed with type 1 diabetes, corresponding to 0.16% of the Portuguese population in this age group.

In the treatment of T1DM, the aim is to achieve metabolic control at an early stage, avoid complications and premature mortality, and maintain the quality of life of adolescents (Korkmaz et al., 2018). Metabolic control is the priority in the treatment of these young people and requires adherence to a therapeutic regimen that includes diet, physical activity, and medication. The insulin production deficit can be compensated by administering insulin through multiple daily injections (MDI) or continuous subcutaneous insulin infusion systems (CSII). In Portugal, most children and adolescents with T1DM are currently undergoing treatment with CSII. This is the result of a new governmental policy (Lei 13277/2016) that determined the access to this therapeutic modality until 2019 for all the eligible paediatric age population. Health professionals are expected to integrate the perspectives of young people in the development, implementation, and evaluation of their interventions. Thus, studies exploring the adolescents' and their families' experiences with treatment with CSII are vital to developing patient-centred health actions. To the best of our knowledge, few studies have been carried out in Portugal documenting the experiences of adolescents on the use of this type of treatment. Therefore, this study aims to better understand the impact of this treatment recently made accessible to all adolescents by evaluating two patient-reported outcomes (PRO), more specifically, health-related quality of life and treatment satisfaction.

1. THEORETICAL FRAMEWORK

Health-related quality of life is a construct that, when used in diabetes, aims to assess the perception of the impact of the illness on the lifestyle and functioning of an individual (Cruz et al., 2018). By providing the comprehension of the experiences associated with T1DM and its different treatments from the adolescent's perspective, its assessment facilitates clinical decision-making processes and knowledge of the effectiveness of the various therapies.

Treatment satisfaction is another PRO usually used to evaluate patients' experiences with the implementation of new therapies. This construct is defined as the patient's self-assessment of the process attributes and the outcomes of the treatment experience. Also, when referring to medical devices, aspects related to their technical features are often considered, such as device appearance and design, usefulness, and potential discomfort in use (Modzelewski et al., 2019).

The treatment with CSII has been studied compared to treatment using multiple daily injections. Evidence shows its greater effectiveness in reducing the variability of blood glucose levels, particularly in reducing episodes of severe hypoglycaemia. Several other advantages have been identified, including decreasing discomfort with needles and consequently increasing adherence to treatment and promoting the prevention of long-term sequelae (Benioudakis et al., 2021). Advances in the features of insulin pumps were also considered important to adolescents‘ satisfaction with this treatment. Over the years, these devices have become more efficient, safe, and user-friendly, with lighter configurations and more discreet, thus becoming more attractive to adolescents (Alsaleh et al., 2012; Alsaleh et al., 2014). The psychosocial advantages of suing CSII in adolescence have also been reported through PROs. Quantitative studies have mainly addressed quality of life (QoL) (Rosner and Roman-Urrestarazu 2018; Silva et al., 2017) and treatment satisfaction (Mueller-Godeffroy et al., 2018). These studies have demonstrated that adolescents perceive this treatment as quite satisfactory and promoting their quality of life. There is also qualitative research that enriches the comprehension of the advantages of this type of treatment identified by adolescents, namely increased functionality, and socialization (Alsaleh et al., 2012; Alsaleh et al., 2014).

However, using CSII is also challenging since it requires constant surveillance and adherence to self-care tasks, such as capillary blood glucose monitoring, carbohydrate counting, and changing catheters every three days. Adolescents also mention the difficulty in wearing clothing that conceals the device and its negative impact on self-image (Alsaleh et al., 2012; Alsaleh et al., 2014). Another important challenge stems from the need for greater autonomy in this period of life, which involves becoming gradually more responsible for their treatment. Also, the parents' overprotective behaviour may likely hinder the adolescents' adaptation process. Furthermore, depending on the development of their newly acquired cognitive abilities, adolescents usually become more aware that T1DM is a life-threatening disease and anticipate potential future consequences, which can negatively impact their emotional well-being (Mueller-Godeffroy et al., 2018).

As previously mentioned, in Portugal, there is little evidence about the quality of life of adolescents with Type 1 diabetes mellitus using CSII. Thus, this study aims to assess key dimensions of quality of life and treatment satisfaction of adolescents with T1DM using CSII and analyse the role of quality of life in predicting treatment satisfaction of adolescents with T1DM using this modality of treatment.

2. METHODS

2.1 Sample

A cross-sectional study was conducted with 77 adolescents with T1DM using CSII, followed-up in the outpatient consultation of the

Paediatric endocrinology department at two central hospitals in the northern region of Portugal. All participants were using the CSII for more than six months prior to the study.

2.2 Data collection instruments and procedures

A sociodemographic (age, gender, education) and a clinical questionnaire (age of diagnosis, last glycated haemoglobin value, frequency of capillary glycaemic testing per day) were applied.

For the evaluation of QoL, the Quality-of-Life Questionnaire for Treatment with Insulin Infusion Pump -adolescents version (QoLTIIP) was used (Sousa 2014). This measure includes ten dimensions: Generic Health and Physical Activity; Feelings and Mood; 'About You'; Family; Friends; School; Leisure time; Money; Future and Impact of Diabetes. Items are assessed on a five-point Likert scale.

The Treatment Satisfaction with Insulin Infusion Pump Questionnaire – adolescents' version (TSIIP) by Sousa (Sousa 2014) was also used. This instrument was adapted from an original version for adults (Apolinário et al., 2010) and includes 40 items that evaluate satisfaction with this modality of treatment, assessed on an ordinal 5-point scale. In addition, a final question was added that asks adolescents how they find the CSII compared to the MDI, with five options: much worse, worse, not worse or better, and better and much better.

The final scores for each dimension of these two questionnaires were recoded to a scale between 0 and 100. The reliability of the instruments was assessed by calculating internal consistency (Table 1). Both measures had acceptable or good reliability scores, except for two dimensions of QoL, namely Generic Health and Leisure Time.

The study was authorized by the ethics committees of the institutions involved according to the Helsinki Declaration [2019.032(028.DEF/029-CE) e CHG31/2019-2]. The adolescents were contacted at the hospital and informed about the study. The adolescents who agreed to participate and whose parents or legal representatives signed an informed consent form, were asked to complete the questionnaire. Privacy, confidentiality, and the protection of personal data were guaranteed.

2.3 Statistical analysis

Data were computed using IBM SPSS version 26.0 for Windows. Pearson's correlation was used to analyse the association between continuous variables and the interpretation of its strength was based on Afonso e Nunes (2019). A T-test for independent samples was used to study means differences between groups. Multiple linear regression was used (Stepwise method) to identify predictors of Treatment Satisfaction.

3. RESULTS

Participants were 77 adolescents, mostly boys (58.4%), aged between 10 and 18 years (M=13.84; SD=2.38). The diagnosis of diabetes occurred on average around the age of 7, and the treatment with the CSII system was typically initiated between the ages of 10 and 13. For 66 participants, it was possible to assess the glycated haemoglobin value for the previous 6 months. The average value of glycated haemoglobin was 7.38 (±7.9), and out of these participants, 57.6% (38) showed reference values equal to or less than 7. Concerning the frequency of capillary glycaemic testing per day, most participants reported that they self-monitored glycaemia around 6, 7 times per day but around more than one-third reported doing it more than 7 times a day, and 10% referred to doing it between 10 to 15 times.

The results showed that most adolescents had a positive perception of their quality of life in all domains. Through the percentiles analysis and considering that the values of each dimension vary between 0 and 100, a positive asymmetric distribution was found in each dimension of the QoLTIIP scale (Table 1).

Table 1 – Descriptives of Quality of life and Treatment Satisfaction.

	Items	Alpha	P25	P50	P75	Mn-Mx	M(SD)
QoLTBII							
Generic H PA	6	.48	76.00	84.00	88.00	52.00-100	88.83(9.78)
Feelings - Mood	11	.84	64.77	75.00	81.82	38.64-95.45	73.20(13.23)
About you	6	.78	62.50	79.17	91.67	29.17-100	75.43(17.24)
Family	3	.78	66.66	83.33	91.66	41.67-100	81.06(16.26)
Friends	5	.86	75.00	85.00	95.00	35.00-100	81.75(15.86)
School	4	.72	68.75	81.25	93.75	43.75-100	79.95(14.80)
Leisure time	2	.57	56.25	75.00	87.50	0-100	71.43(21.06)
Money	1	—	75.00	75.00	100.00	25.00-100	81.17(21.89)
Future	3	.82	58.33	75.00	91.67	25.00-100	74.02(20.05)
DM Impact	18	.86	55.56	66.67	74.31	19.44-94.44	63.99(15.69)
TSIIP	40	.96	48.83	64.54	76.39	44.49-96.33	68.38(14.8)

Legend: Generic H PA – Generic Health and Physical Activity; QoLTBII - Quality of Life questionnaire for treatment with Insulin Infusion Pump – adolescents; TSIIP – Treatment Satisfaction with Insulin Infusion Pump questionnaire; P25 – Percentile 25; P50 – Percentile 50; P75 – Percentile 75;

The Generic Health and Physical Activity dimension scored the highest (M=88.83; SD=9.78), and the scores of the items included in this dimension showed that adolescents reported not feeling sick (M=4.7; SD=0.56) and not considering having limitations in sports practices (M=4.66; SD=0.77) and daily life activities (M=4.51; SD=1.01).

The dimensions of Family, Friends, Money and School also had a mean score equal to or above 80 (Table 1), showing that participants perceived good support both from family and friends, were satisfied with the allowance they had for their personal expenses and were happy about their school life.

The lowest mean score was found in the Impact of Diabetes dimension (M=63.99; SD=15.69), revealing the perceived burden of diabetes on the adolescent's perceived quality of life. In this dimension, participants reported that they were not satisfied with their family's knowledge about T1DM and CSII (M=1.56; SD=0.89), and they feared the worsening of T1DM (M=2.83; SD=1.48). They also reported being afraid of hyperglycaemia (M=3.09; SD=1.38) and hypoglycaemia events (M=3.17; SD=1.39).

Adolescents reported being satisfied with the treatment with CSII, with a total mean score of 68.38 (Table 1). The items with the higher scores revealed the adolescents perception that CSII facilitated the administration of insulin (M=4.23; SD=0.67), the calculation of bolus for meals (M=4.21; SD=0.80), provided autonomy (M=4.23; SD=0.76) and comfort (M=4.13; SD=0.82). The aspects that adolescents evaluated as less satisfactory in the treatment with CSII were those related to the body marks caused by the cannula in the skin (M=2.81; SD=1.91) and the needle in the measurement of capillary blood glucose (M=3.05; SD=0.96), the need to adapt clothing to cover the device (M=3.30; SD=1.18), and the discomfort associated with carrying the pump (M=3.36; M=1.06).

When asked to compare treatment with insulin pump with treatment with multiple injections, most adolescents (94.5%) considered that CSII was better than MDI.

The second objective was to identify the role of quality of life in predicting treatment satisfaction. First, the association between the different dimensions of quality of life and treatment satisfaction was studied using Pearson's r (Table 2). Results showed an association between the different dimensions of quality of life, except for Leisure Time, thus contributing to the evaluation of quality of life of adolescents undergoing treatment with CSII. Also, all dimensions of quality of life were significantly associated with treatment satisfaction total score and with both dimensions concerning the overall treatment and technical features of CSII. The association between age and age of diagnosis, and quality of life and treatment satisfaction were also studied (table 2). Results showed that age was only associated with School, Future and Impact of Diabetes. Weak correlations were found between age of diagnosis and leisure, future and treatment satisfaction. Gender was also studied as a possible influence on quality of life, but no differences were found between girls and boys.

Table 2 – Association between the Quality-of-Life scale and treatment satisfaction with Insulin Infusion Pump, age and age of diagnosis.

	GHPA	FM	About you	Family	Friends	School	LT	Money	Future	DM Impact	TSIIP
QoLTBII											
FM	.575**										
About you	.364**	.657**									
Family	.285*	.533**	.623**								
Friends	.252*	.563**	.467**	.517**							
School	.369**	.559**	.363**	.286*	.528**						
Leisure time	.142	.312**	.308**	.244*	.140	.150					
Money	.393**	.490**	.436**	.325**	.385**	.558**	.191				
Future	.264*	.455**	.375**	.430**	.507**	.430**	.024	.226*			
DM Impact	.531**	.475**	.199	.021	.156	.444**	.086	.462**	.176		
TSIIP	.264*	.488**	.371**	.318**	.354**	.328**	.353**	.451**	.243*	.430**	
Age	.042	-.014	-.133	-.143	.192	.316**	-.198	.183	.231*	.337**	.128
Age Dig	-.051	.035	.160	.000	.068	.091	.229*	.271*	.106	.117	.260*

Legend: GH PA – Generic Health and Physical Activity; FM - Feelings Mood; A you – About you; LT- Leisure time; QoLTBII - Quality of Life questionnaire for treatment with Insulin Infusion Pump – adolescents; TSIIP – Treatment Satisfaction with Insulin Infusion Pump questionnaire; Age Dig – age of diagnosis.

The results from a multiple regression using a stepwise method are summarized in Table 3. Except for Money, all dimensions of QoL were entered in the model as predictors of treatment satisfaction (total score). The model was found statistically significant (F(3.73)=11.850; p=0.000), with only three dimensions contributing to explaining 32.7% (adjusted R2 value) of treatment satisfaction. Those dimensions were Feelings and Mood (B=0.299; *t*=2.610; *p*=0.11), Leisure Time (B=0.239; *t*=2.359; *p*=0.21) and Impact of Diabetes (B=0.241; *t*=2.200; *p*=0.31). The variable that explained most of the variance of treatment satisfaction was Feelings and Mood (23.8%) and Leisure Time and Impact of Diabetes explained 4.5% each.

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Table 3 – Results of linear regression analysis.

Model	Unstand. Coef. B	Std. error	Standardized Coef. Beta	*t*	*p*
(Constant)	39.286	17.303		2.270	.026
Diabetes Impact	.663	.254	.299	2.610	.011
Feelings and Mood	.333	.141	.239	2.359	.021
Leisure time	.449	.204	.241	2.200	.031

Notes: Dependent variable: Satisfaction with DM treatment

4. DISCUSSION

These study results suggest that the use of CSII is a therapeutic modality perceived by adolescents with T1DM as globally satisfactory and promoting their quality of life, which is in line with existing evidence (Hussain et al., 2017; Rosner and Roman-Urrestarazu, 2018). This study also suggests that the use of CSII is a therapeutic response that enables good metabolic control since most participants showed an HbA1c value within the therapeutic target (DGS, 2019). As previously mentioned, its effectiveness has been demonstrated through several empirical studies (Benioudakis et al., 2021; Driscoll et al., 2016), systematic reviews, meta-analysis (Cherubini et al., 2014), multicentric studies (Lukács et al., 2018), and longitudinal studies (Observatório da diabetes, 2016).

Notably, most studies previously developed on the QoL of adolescents using CSII were comparative studies, in which adolescents compared the CSII with the multiple injection system, a type of treatment that participants in this study also experienced before starting treatment with the insulin pump. Literature shows that, compared to MDI, the use of CSII is associated with a higher quality of life, both globally (Shaikh et al., 2020) and in its various dimensions (Rosner & Roman-Urrestarazu, 2018; Silva et al., 2017).

In this study, quality of life was evaluated in different domains or functioning areas, however, the association found between all these dimensions demonstrates that they all contribute to the assessment of the overall quality of life. The Generic Health and Physical Activity was the dimension with the highest score, revealing that adolescents had a very positive perception of their physical functionality and perceived themselves as healthy people, as found in a study by Silva and al. (2017). Globally, studies on quality of life of adolescents with T1DM in different types of treatment produced outcomes that pointed to a very positive perception of health, being the groups with CSII reporting the best results concerning this indicator (Hussain et al., 2017). Health perception has been increasingly emphasized in research as an important outcome variable, and some evidence has further proven that this indicator is more significantly associated with HbA1c than with the type of therapeutic regimen (Keller et al., 2017).

Participants also reported being satisfied with the Support from family and friends. These two dimensions reflect aspects more often denominated as perceived social support, and again, these findings are in line with those of other studies that highlight the importance of family (Alvarenga et al., 2022) and friends (Özyazıcıoğlu et al., 2017) to the adolescent's quality of life.

Concerning quality of life in the school dimension, the average score obtained was also high. In a systematic review involving qualitative studies, adolescents referred to more flexible management of their lifestyles concerning social activities and school life as one of the advantages of CSII treatment (Alsaleh et al., 2012). More specifically, this study emphasized that adolescents viewed the use of the insulin pump as an advantage since it prevented them from leaving the classroom to find a space that could offer some privacy for the administration of insulin. As such, treatment with CSII, besides not interfering with the learning activities, also prevents the potential drawing of unwanted attention likely to cause discomfort and embarrassment (Alsaleh et al., 2012).

The scores for the dimensions relating to Feelings, Mood and Leisure Time were relatively lower. The results for Feelings and Mood are probably explained by the emotional burden of living with T1DM. The cognitive development during adolescence enables to better understand the chronicity of T1DM and consequently fear potential long-term consequences that can negatively impact the health and well-being of these adolescents (Mueller-Godeffroy et al., 2018).

Of all the QoL dimensions, the Impact of Diabetes scored the lowest. The items assess specific aspects of the adaptation to T1DM and management of the therapeutic regimen, which are usually present in specific instruments for the evaluation of quality of life associated with T1DM. This result suggests that although treatment can help normalise the functionality of these adolescents, the perception of some burden and the difficulties inherent to experiencing a chronic disease continue to linger and affect the adolescents' well-being. In this dimension, the fear of decompensation due to the occurrence of hyperglycaemia and hypoglycaemia was reported as one of the most negative aspects in the management of the disease. This type of fear, which is frequent due to the rather stressful and serious nature of this event, is also commonly described in the literature for all treatment modalities (Driscoll et al., 2016). The present study also produced another result that reinforces the importance of considering this fear when providing support to these adolescents, that is, a considerable number of adolescents continue to self-monitor glycaemia more often than necessary, and only two-thirds have an average frequency of capillary glycaemic testing of 5 or 6 times a day, as recommended by recent guidelines (DGS, 2019).

Adolescents were globally satisfied with the CSII system. When asked about their satisfaction with the CSII system, almost all participants stated that they preferred this therapeutic option over the MDI system, also corroborating the results from previous research (Brew-Sam et al., 2021; Hussain et al., 2017; Mueller-Godeffroy et al., 2018; Silva et al., 2017). They also reported that they were particularly satisfied with the increased comfort and flexibility concerning their lifestyles and preserved autonomy.

These aspects were also observed in some studies, demonstrating that these are important aspects in the satisfaction with this type of treatment (Alsaleh et al., 2012). Regarding aspects that were evaluated as less satisfactory about the use of CSII, issues associated with the implications on the adolescent's self-image were highlighted, namely the skin marks caused by the catheters and the need to adapt clothes to cover the device. Again, the interpretation of these results is at least partly explained by the developmental tasks of adolescence since there is a need to develop a personal identity, but also great dependence on peer approval, which makes it difficult to accept oneself as different (Mueller-Godeffroy et al., 2018).

Another aim of this study was to identify the role of the different dimensions of quality of life as predictors of satisfaction with CSII treatment. The analysis of the results of the association between these variables, showed that there was a positive association between quality of life and satisfaction with CSII treatment, as found previously (Haas et al., 2020). Three variables were also found as significant predictors explaining more than one-third of the variance of treatment satisfaction, namely Feelings and Mood, Impact of Diabetes and Leisure Time. Interestingly, these were the dimensions with the lowest scores, pointing to the need to focus on the emotional needs of adolescents when developing interventions aimed to promote adjustment to diabetes and satisfaction with treatment with CSII. Another important focus of attention emerging from the results concerns the integration of CSII with leisure activities, since this area was also found to be a determinant of satisfaction with this treatment. As discussed earlier, developmental tasks of adolescence require building up an identity and the acquisition of more autonomy but also greater opportunities for socialization with peers. All these tasks can be compromised by the presence of T1DM, especially if treatment is not perceived as satisfactory and secure.

CONCLUSION

A recent governmental policy has provided adolescents in Portugal with access to treatment of T1DM with CSII. The evidence on the impact of this treatment is still relatively scarce, so the present study aimed to study quality of life and treatment satisfaction of adolescents with T1DM using CSII and to analyse the role of quality of life in predicting treatment satisfaction in adolescents with T1DM using this modality of treatment.

Most participants perceived good global quality of life, however, they expressed a lower perception in areas related to diabetes management, emotional well-being, and leisure, which in turn, were found to explain one-third of the variance of treatment satisfaction in the predictive analysis.

Overall, adolescents were satisfied with the CSII system and considered it convenient, easy to use, and promotes their autonomy.

Despite the limitations of this study, because of its cross-sectional design and relatively small sample size, this research is likely to contribute to the development of interventions aimed at facilitating the adolescent's adjustment to treatment with the insulin pump. Adolescents and families should be assisted in developing strategies for emotional management and coping with the implications of treatment in areas like self-image and how to handle the technical aspects of CSII appropriately. The assessment of PROs like quality of life and treatment satisfaction can also help health professionals provide individualized care to adolescents with T1DM undergoing treatment with insulin pump.

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INTERVENÇÕES DE ENFERMAGEM NA PESSOA EM CUIDADOS PALIATIVOS COM FADIGA: UMA SCOPING REVIEW

NURSING INTERVENTIONS IN THE PERSON IN PALLIATIVE CARE WITH FATIGUE: A SCOPING REVIEW

INTERVENCIONES DE ENFERMERÍA EN LA PERSONA EN CUIDADOS PALIATIVOS CON FATIGA: REVISIÓN DEL ALCANCE

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RESUMO

Introdução: A fadiga é um dos sintomas mais comuns na pessoa em situação paliativa que afeta a sua qualidade de vida e, cuja gestão permanece um desafio.
Objetivo: Mapear as intervenções de enfermagem utilizadas no controlo da fadiga na pessoa em situação paliativa.
Métodos: Scoping Review de acordo com a metodologia do Joanna Briggs Institute. Dois investigadores independentes realizaram a análise, extração e síntese dos resultados.
Resultados: Intervenções de enfermagem como Intervenção Psicossocial, Massagem Aromática, Cuidados paliativos standard, Intervenção colaborativa Online, Terapia Cognitivo Comportamental, Exercício físico e acupuntura foram identificadas.
Conclusão: Os estudos apontam para intervenções multidisciplinares multimodais, onde o enfermeiro tem um papel primordial. No entanto, não há estudos em pessoas numa fase terminal da sua doença, ou seja, nos últimos meses ou dias de vida, pelo que se sugerem novas investigações sobre a eficácia das intervenções no controlo da fadiga da pessoa em cuidados paliativos e a adoção de estratégias que permitam melhorar o conhecimento dos profissionais de saúde sobre o impacto da fadiga.

Palavras-chave: cuidados paliativos; fadiga; enfermagem

ABSTRACT

Introduction: Fatigue is one of the most common symptoms in patients in palliative care that affects their quality of life and whose management remains a challenge.
Objective: To map the nursing interventions used to control fatigue in people in palliative situations.
Methods: Scoping Review according to the Joanna Briggs Institute methodology. Two independent researchers performed the analysis, extraction and synthesis of the results.
Results: Nursing interventions such as Psychosocial Intervention, Aromatic Massage, Standard Palliative Care, Online Collaborative Intervention, Cognitive Behavioural Therapy, Physical Exercise and acupuncture were identified.
Conclusion: The studies point to multidisciplinary multimodal interventions, where the nurse has a primary role. However, there are no studies in patients in a terminal phase of their disease, that is, in the last months or days of life, so further research is suggested on the effectiveness of interventions to control patient fatigue in palliative care and the adoption of strategies that improve the knowledge of health professionals about the impact of fatigue.

Keywords: palliative care; fatigue; nursing

RESUMEN

Introducción: La fatiga es uno de los síntomas más comunes en pacientes en cuidados paliativos que afecta su calidad de vida y cuyo manejo permanece un desafío.
Objetivo: Mapear las intervenciones de enfermería utilizadas para el control de la fatiga en personas en situaciones paliativas.
Métodos: Scoping Review según la metodología del Joanna Briggs Institute. Dos investigadores independientes realizaron el análisis, extracción y síntesis de los resultados.
Resultados: Se identificaron intervenciones de enfermería como Intervención Psicosocial, Masaje Aromático, Cuidados Paliativos Estándar, Intervención Colaborativa Online, Terapia Cognitivo-Conductual, Ejercicio Físico y Acupuntura.
Conclusión: Los estudios apuntan a intervenciones multidisciplinares multimodales, donde el enfermero tiene un papel primordial. Sin embargo, no existen estudios en pacientes en fase terminal de su enfermedad, es decir, en los últimos meses o días de vida, por lo que se sugiere profundizar en la investigación sobre la efectividad de las intervenciones para el control de la fatiga del paciente en cuidados paliativos y la adopción de estrategias que mejoran el conocimiento de los profesionales de la salud sobre el impacto de la fatiga.

Palabras Clave: cuidados paliativos; fatiga; enfermería

INTRODUCTION

According to the International Association for Hospice and Palliative Care (Radbruch, et al., 2020, p.755), palliative care is "holistic, active care provided to individuals of all ages with intense suffering resulting from serious illness, especially aimed at those near the end of life. The aim is to improve the quality of life of sick people, their families, and caregivers."
Advances in medical treatments for patients with incurable diseases have led to a prolongation of survival. Today, patients with incurable cancer undergoing cancer therapy with palliative intent, can remain in a chronic disease process for a period of time lasting years (Poort et al., 2017, p.6).

According to the Australian National Sub-acute and Non-acute Patient, a terminal illness is associated with four palliative phases, which are described and based on individual characteristics of the suffering presented by each patient. Thus, the four palliative phases are associated with the stage of the disease, where each of them corresponds to a different level of complexity: the acute phase, the deterioration phase, the terminal phase and the stable phase.

For Radbruch et al. (2008) fatigue is one of the most common symptoms in people in palliative care, affecting more than 80% of patients. For the authors it is described as “a subjective feeling of tiredness, weakness and lack of energy” that affects the person physically, emotionally and cognitively, not only the cancer patient, but also the patient with non-oncological pathology.

According to National Comprehensive Cancer Network (NCCN) cancer-related fatigue is “a distressing, persistent and subjective feeling of physical, emotional, and/or cognitive tiredness or exhaustion related to cancer or its treatment that is not proportional to recent activity and interferes with normal functioning (Berger, 2020, p. FT-1). Poort et al. (2017, p.3) add that, in addition to being a prevalent symptom, fatigue is also a factor that affects the patient’s quality of life.

In patients with advanced cancer, fatigue is associated with a multitude of factors such as sociodemographic, clinical (functional status of the patient and cancer treatment), biological parameters (serum levels of haemoglobin and albumin) and lack of control of other physical symptoms, such as pain or dyspnea (Ghoshal et al., 2017).

According to Klasson, Frankling, Hagelin & Björkhem-bergman (2021, p.5) the aetiology of fatigue “may differ in the initial palliative phase compared to the late phase. In the initial phase, fatigue and change in fatigue often show an association with biomarkers of inflammation. However, in the late stage, close to death, an improvement in fatigue is often difficult to achieve and recovery of inflammatory biomarkers is rarely possible.

The experience of fatigue in the last days of life is also influenced by other symptoms and the fact that life comes to an end. Despite the same influential aetiology, the experience and meaning of fatigue may differ at the end of life compared to earlier palliative phases.”

Thus, fatigue is a symptom whose management remains a challenge, not only because of the above, but also because of the overlap of other specific symptoms of the disease, and because of the lack of evidence of the effectiveness of interventions in the context of palliative care (Ingham & Urban, 2020, p.59).

In a study carried out in Australia, whose objective was to understand the attitudes of palliative care health professionals towards fatigue, Ingham & Urban (2020) found that most participants recognized fatigue as a common symptom, associating it with a normal course of incurable disease, not recognizing this symptom, when severe, as potentially more impacting than pain. In the same study, the authors also verified that health professionals considered strategies based on exercise and energy conservation, and intervention aimed at the patient’s expectations in the control of fatigue consensual. On the other hand, they identified the following as barriers: lack of time and resources, low capacity and motivation of patients who adopt an attitude of resignation in the face of fatigue, factors associated with the disease such as the coexistence of other uncontrolled symptoms, difficulty in measuring fatigue by the patient, who confuses the level of the symptom with the level of suffering caused by it and by the limited therapeutic options (Ingham & Urban, 2020, p.62).

According to the literature, fatigue management “involves a multidimensional strategy, divided into pharmacological and non-pharmacological strategies” (Poort et al. 2017, p.6). In a narrative review of pharmacological interventions, Klasson, Frankling, Hagelin & Björkhem-bergman (2021, p.1) concluded that “the evidence is still weak for the use of pharmacological treatments for fatigue in patients in palliative care, although methylphenidate and corticosteroids may be considered in their treatment.

Taking into account the little evidence about nursing interventions aimed at improving care delivery in controlling fatigue, we decided to carry out a scoping review with the aim of mapping nursing interventions used to control fatigue in the person in palliative care. The aim of this is to answer the research question: What are the nursing interventions used to control fatigue in people in palliative situations?

1. METHODS

The study was conducted in accordance with the methodology proposed by the Joanna Briggs Institute (JBI) for Scoping Reviews (Peters et al., 2020). A research protocol was developed defining the inclusion criteria, the limitations, the research question, the time limit, the Boolean phrase, among other considerations presented below.

The question was based on the acronym PCC (Population, Concept and Context), where the Population corresponded to Patients with fatigue, the Concept to Interventions for the control of fatigue and the Context to Palliative Care.

Having defined the terms of the question, the researchers defined studies with adults in palliative situations and nursing interventions in the control of fatigue as inclusion criteria. The search limitations defined by the investigators were articles written in Portuguese, English or Spanish and the time limit from 2016 to 2021.

The DeCS/MeSH and CINAHL Headings descriptors were identified and the Boolean phrase was elaborated:

> (TI (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH "Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices")) OR AB (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH "Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices"))) AND (TI ((MH "fatigue") OR (MH "Asthenia") OR " symptom fatigue ") OR AB ((MH "fatigue") OR (MH "Asthenia") OR " symptom fatigue "))

The search strategy included both published and unpublished sources of evidence and comprised 3 steps. In the first stage (03/6/2021) a search was carried out in the CINAHL Complete, MEDLINE Complete and Cochrane Central Register of Controlled Trials databases through the content aggregator EBSCOHost. In the second stage (03/10/2021) the search terms were replicated in Scopus, in RCAAP (Portuguese Open Access Scientific Repositories available at https://www.rcaap.pt/) and in Google Scholar. In the third step, the bibliographic references of eligible articles were examined in order to identify additional studies.

After analysing the eligible articles, the time limit was applied, due to the redundancy of the results. The articles were analysed by two independent researchers. In situations where there was no consensus among the researchers, evaluation by a third researcher was requested. Rayyan and Mendeley software was used to manage the bibliographic references.

To extract the results, and in accordance with the JBI (2020), an instrument was prepared with data on the authors, year of publication, origin, study objectives, population and sample size within the source of evidence (if applicable), methodology/methods, type of intervention, duration of intervention (if applicable) and results. Two independent researchers performed data extraction and synthesis. Situations of uncertainty were resolved through discussion with a third researcher.

Since the objective of a scoping review is to determine what type of evidence is available, regardless of quality, the methodological quality of the studies was not evaluated.

2. RESULTS

The studies were analysed according to the Prism Diagram. The research carried out identified 619 studies with potential relevance, as shown in Figure 1. Of these, 153 were excluded because they were duplicates. Of the 466 records analysed, 400 were excluded after the title and abstract had been evaluated and 46 for not meeting the stipulated time limit. After the evaluation, 20 articles were selected which, after full reading, led to the exclusion of 5 articles for context and 6 for concept, since they did not meet the inclusion criteria. Finally, 9 articles were included in this review.

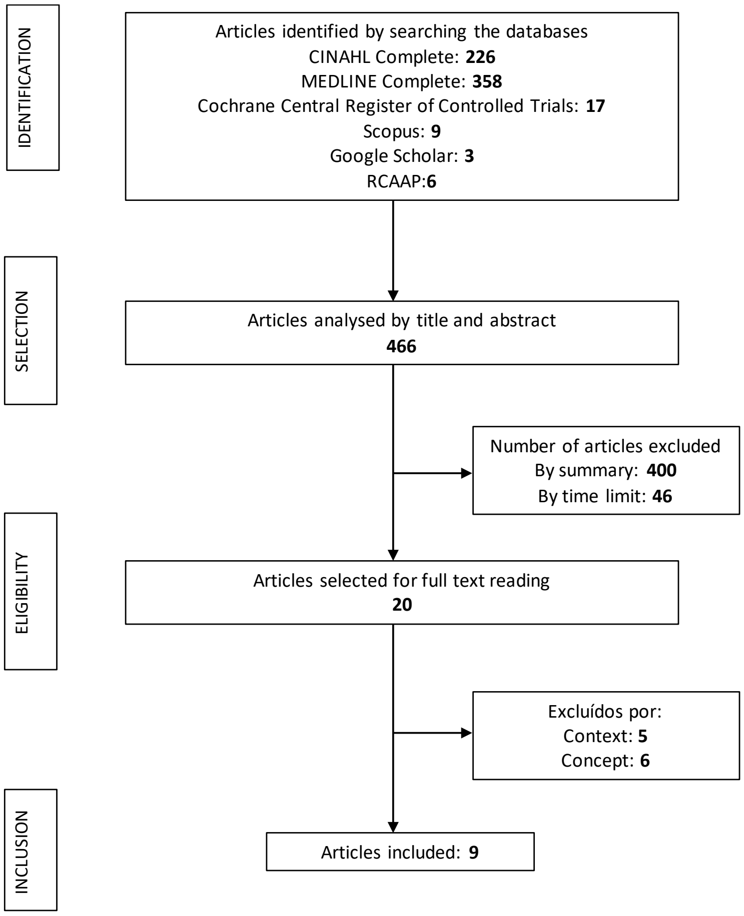

Figure 1 – Diagram with selection of studies according to (PRISMA, 2009)

The nine articles included in the study and which were part of the analysis corpus are presented below (Table 1).

Table 1 – Studies included in the review

Studies Included
Poort, H., Peters, M. E. W. J., van der Graaf, W. T. A., Nieuwkerk, P. T., van de Wouw, A. J., Nijhuis-van der Sanden, M. W. G., Bleijenberg, G., Verhagen, C. A. H. H. V. M., & Knoop, H. (2020). Cognitive behavioral therapy or graded exercise therapy compared with usual care for severe fatigue in patients with advanced cancer during treatment: a randomized controlled trial.
Zuo, X.-L., Wen, Y., Gong, S.-Q., & Meng, F.-J. (2019). Effectiveness of integrated nursing interventions for fatigue in patients with advanced cancer: A systematic review of randomized controlled trials.
Koesel, N., Tocchi, C., Burke, L., Yap, T., & Harrison, A. (2019). Symptom Distress: Implementation of Palliative Care Guidelines to Improve Pain, Fatigue, and Anxiety in Patients With Advanced Cancer.
Miller, K. R., Patel, J. N., Symanowski, J. T., Edelen, C. A., & Walsh, D. (2019). Acupuncture for Cancer Pain and Symptom Management in a Palliative Medicine Clinic.
Poort, H., Peters, M., Bleijenberg, G., Gielissen, M. F., Goedendorp, M. M., Jacobsen, P., Verhagen, S., & Knoop, H. (2017). Psychosocial interventions for fatigue during cancer treatment with palliative intent.
Ghoshal, A., Salins, N., Deodhar, J., Damani, A., & Muckaden, M. A. (2017). Impact of symptom control on fatigue improvement in patients with advanced cancer: A prospective observational study.
Cheng, C., Chen, L., Ning, Z., Zhang, C., Chen, H., Chen, Z., Zhu, X., & Xie, J. (2017). Acupuncture for cancer-related fatigue in lung cancer patients: a randomized, double blind, placebo-controlled pilot trial.
Park, H., Chun, Y., & Kwak, S. (2016). *The effects of aroma hand massage on fatigue and sleeping among hospice patients*.
Steel, J. L., Geller, D. A., Kim, K. H., Butterfield, L. H., Spring, M., Grady, J., Sun, W., Marsh, W., Antoni, M., Dew, M. A., Helgeson, V., Schulz, R., & Tsung, A. (2016). Web-based collaborative care intervention to manage cancer-related symptoms in the palliative care setting.

As previously mentioned for extracting the results, and according to the JBI (2020), a summary table of the articles selected for analysis was prepared in order to present the results and map the revised material in a logical and descriptive way (Table 2).

Table 2 – Summary table of articles selected for analysis

Year	Authors	Methodology	Results
2020	Poort et al.	Randomized study	Cognitive-behavioural therapy reduced fatigue and improved quality of life and functional capacity up to 3 months after the intervention. Regarding physical exercise, there was no statistically significant reduction in fatigue levels.
2019	Zuo, Wen, Gong & Meng	Systematic review	The collaborative intervention through a multidisciplinary team composed of professionals, patient and caregiver, proved to be a beneficial intervention in the control of fatigue. The provision of personalized care based on a protocol, psychoeducation, which includes interventions such as relaxation, imagination and distraction, passive exercises with the patient seated, ensuring a balance between activity and rest, cognitive- and a qigong, which includes body awareness training, relaxation and massage, has been shown to have positive results in controlling fatigue and muscle strength in patients undergoing chemotherapy.
2019	Koesel, Tocchi, Burke, Yap & Harrison	Pre- and post-test study	Statistically significant decrease in fatigue scores according to ESAS, after implementation of the safety guidelines palliative care American Society of Clinical Oncology (ASCO) in palliative care consultations.
2019	Miller, Patel, Symanowski, Edelen & Walsh	Retrospective study	There is a statistically significant improvement in fatigue control after the first acupuncture treatment and during the remainder, with the improvement in fatigue levels being correlated with the reduction in pain levels.
2017	Poort et al.	Systematic review	The results do not support the effectiveness of psychosocial interventions in reducing fatigue.
2017	Ghoshal, Salins, Deodhar, Damani & Muckaden	Retrospective observational study	The study showed that palliative care consultation is associated with an improvement in fatigue control at the time of the first follow-up (2-4 weeks after the intervention).
2017	Cheng et al.	Randomized Clinical Trial	The level of fatigue was reduced after 2 weeks in the group of participants who received acupuncture (8 sessions of 45 minutes, for 4 weeks, 2 per week) when compared with those who received a placebo treatment.
2016	Park, Chun, & Kwak	Comparative study	No statistically significant differences were found between groups
2016	Steel et al.	Randomized study	Collaborative care interventions involving nurses, physicians, psychologists, patients and caregivers reduce stress, pain and fatigue and improve the quality of life of patients with advanced cancer.

3. DISCUSSION

Currently, palliative care is increasingly recognized in Portugal, as part of the National Health System. The approach to this issue, in recent years, has been increasing due to both the aging of the population and the increase in more complex health conditions resulting from the higher prevalence of neoplasms, chronic or degenerative diseases. Palliative care is centred on an approach whose aim is to promote the quality of life of the person and their families, through the correct assessment and control of physical, social, emotional and spiritual symptoms that develop in the context of the disease (OMS, 2002). Care is provided by a multidisciplinary team during the period of diagnosis, illness, end of life and bereavement.

The palliative approach integrates a set of methods and procedures that must be used and that involve pharmacological and non-pharmacological measures to control symptoms in following up patients. Despite advances in recent years, cancer-related fatigue is an underappreciated symptom, understood as a natural part of the disease process and is, therefore, undertreated.

From analysing the articles, a set of consistent non-pharmacological interventions stands out, although there is some contradictory evidence.

In fact, people in situations with palliative needs require specialized care provided by their own multidisciplinary teams, with specialized skills, focused on optimizing their quality of life. In a retrospective observational study carried out in India on 500 patients with advanced cancer for whom standard palliative care was implemented and follow-up consultations were introduced after the initial intervention, Ghoshal et al. (2017) concluded that patients with continuous follow-up between two to four weeks after the intervention showed improvement in fatigue control. In the USA, Koesel et al. (2019) implemented the American Society of Clinical Oncology (ASCO) guidelines for palliative care with the aim of evaluating the reduction of symptoms, such as pain, fatigue and anxiety after its implementation in follow-up consultations. They studied 31 patients who applied the Edmonton Symptom Assessment Scale (ESAS). The ESAS scores for pain, fatigue, and anxiety were measured before consultation and at two subsequent visits. After implementing the guidelines, they observed a statistically significant decrease in ESAS fatigue scores at the three time points.

The analysis of these studies reveals the importance of monitoring by a team that provides palliative care. This idea is reinforced in the study by Steel et al. (2016), a randomized controlled trial conducted with 261 patients with advanced cancer and 179 caregivers, which examined the effectiveness of a collaborative care intervention. The collaborative care team included nurses, as coordinators, doctors, psychologists, the patient and his caregiver. The study demonstrated that collaborative teamwork reduces depression, pain and fatigue, and improves the quality of life of the cancer patient. In the study, the team monitored symptoms online or over the phone. Interventions included education, self-management, journaling, a chat room, an audiovisual library and peer support. Tele-monitoring and online interventions were recommended for patients with advanced cancer, reducing not only the symptoms of the disease but also the costs of healthcare.

These studies show that the existence of specialized, trained and dedicated teams that adopt a collaborative intervention involving a multidisciplinary team composed of doctors, nurses, psychologists, patients and family members is fundamental to control fatigue in the person in a palliative situation, particularly if a set of non-pharmacological strategies are adopted.

In a systematic review of 14 randomized studies, Poort et al. (2017) showed that psychosocial interventions performed individually or in groups, by psychologists or nurses were not effective in reducing fatigue. However, in a randomized controlled study carried out in 134 patients with locally advanced or metastatic cancer, with severe fatigue and with a life expectancy of more than six months undergoing cognitive-behavioural therapy in 2020, Poort et al., obtained reduced fatigue and improved quality of life and functional capacity when compared with the group that received usual care (control group). These two results, although controversial, suggest that cognitive-behavioural therapy may play an important role in reducing fatigue.

Even though the study by Poort et al. (2020) also encompasses physical exercise, the authors concluded that it did not produce a statistically significant reduction in fatigue levels. Ingham & Urban (2020) add that both physical exercise and cognitive-behavioural therapy are two interventions with high evidence in the control of fatigue. However, there is a lack of studies that identify which exercises are recommended and their relationship with the staging of the disease. Studies conducted outside the context of palliative care indicate strength/resistance exercises and aerobic exercises.

Regarding the collaborative intervention of a multidisciplinary team focused on providing personalized care based on protocols, there are several studies that describe a set of non-pharmacological interventions with effective results in the control of fatigue. In their systematic review involving six randomized studies, with 736 adult patients with advanced cancer, undergoing non-pharmacological interventions directed by nurses, Zuo, Wena, Gongb and Mengb (2019) identified relaxation, guided imagery and distraction, passive exercises with the patient seated, ensuring a balance between activity and rest, cognitive-behavioural intervention, acupuncture and *qigong*, which includes body awareness training, relaxation and massage as beneficial interventions in the control of fatigue. All interventions were shown to have positive results in the control of fatigue and muscle strength in the patient undergoing chemotherapy. Cheng et al. (2017), performed a randomized clinical trial with 28 patients diagnosed with small cell lung carcinoma, under chemotherapy and radiotherapy with fatigue and found that the level of fatigue reduced after two weeks in the group of participants who received acupuncture sessions when compared to with the group that received placebo treatment. In a retrospective study of all patient files referred to in the Levine Cancer Institute Section of Palliative Medicine, undergoing acupuncture for the treatment of pain and other symptoms, Miller et al. (2019) concluded that there was a statistically significant improvement in fatigue control after the first acupuncture session and during the others, with improvement in fatigue levels being correlated with the reduction in pain levels. In South Korea, Park et al. (2016) compared the effects of massage intervention, with and without aromatherapy, in order to understand its influence on the level of fatigue and sleep of patients in palliative care units in a sample of 30 patients; however, they did not find statistically significant differences between groups.

Although some non-pharmacological interventions in some studies have not shown statistically significant differences, most of them allow us to conclude that there is a set of non-pharmacological interventions such as: relaxation, distraction or guided imagery, passive exercises, cognitive-behavioural intervention, acupuncture and massage with or without aromatherapy, which produce effects in the control of fatigue in the person in palliative care.

CONCLUSION

The study made it possible to verify that consensual interventions go through a multidisciplinary multimodal intervention, in which the nurse plays a key role, including interventions in the context of individual physical exercise combined with energy conservation strategies (passive exercises), education and counselling (sleep hygiene). and diet) and cognitive-behavioural therapy. There is also a set of non-pharmacological interventions integrated in a collaborative intervention of a multidisciplinary team such as massage, acupuncture, relaxation, distraction or guided imagery that reduce the effect of fatigue. It has also been found that interventions in the scope of palliative care, where the philosophy focuses on the patient and family at the centre of care, on symptom control, on communication and on teamwork, show positive results in fatigue control. Similarly, in the person in palliative care, where the objective is to provide maximum comfort, it is necessary to balance the impact of fatigue with targeted interventions.

The studies were found to include people at different stages of their disease, namely cancer patients undergoing curative therapy, cancer survivors and patients in a palliative phase. However, there are no studies in patients in the terminal phase of their disease, that is, in the last months or days of life. Consequently, further investigations are suggested on the effectiveness of interventions to control fatigue in palliative care patients at this stage of the disease.

IMPLICATIONS FOR PRACTICE

This study highlights that for the control of fatigue in the person in palliative care, a multidisciplinary multimodal intervention is essential, involving a team of professionals with diversified skills who work complementarily, adopting a treatment plan that involves pharmacological and non-pharmacological interventions.

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INTERVENÇÕES DE ENFERMAGEM NA PESSOA EM CUIDADOS PALIATIVOS COM FADIGA: UMA SCOPING REVIEW
NURSING INTERVENTIONS IN THE PERSON IN PALLIATIVE CARE WITH FATIGUE: A SCOPING REVIEW
INTERVENCIONES DE ENFERMERÍA EN LA PERSONA EN CUIDADOS PALIATIVOS CON FATIGA: REVISIÓN DEL ALCANCE

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RESUMO

Introdução: A fadiga é um dos sintomas mais comuns na pessoa em situação paliativa que afeta a sua qualidade de vida e, cuja gestão permanece um desafio.

Objetivo: Mapear as intervenções de enfermagem utilizadas no controlo da fadiga na pessoa em situação paliativa.

Métodos: Scoping Review de acordo com a metodologia do Joanna Briggs Institute. Dois investigadores independentes realizaram a análise, extração e síntese dos resultados.

Resultados: Intervenções de enfermagem como Intervenção Psicossocial, Massagem Aromática, Cuidados paliativos standard, Intervenção colaborativa Online, Terapia Cognitivo Comportamental, Exercício físico e acupuntura foram identificadas.

Conclusão: Os estudos apontam para intervenções multidisciplinares multimodais, onde o enfermeiro tem um papel primordial. No entanto, não há estudos em pessoas numa fase terminal da sua doença, ou seja, nos últimos meses ou dias de vida, pelo que se sugerem novas investigações sobre a eficácia das intervenções no controlo da fadiga da pessoa em cuidados paliativos e a adoção de estratégias que permitam melhorar o conhecimento dos profissionais de saúde sobre o impacto da fadiga.

Palavras-chave: cuidados paliativos; fadiga; enfermagem

ABSTRACT

Introduction: Fatigue is one of the most common symptoms in patients in palliative care that affects their quality of life and whose management remains a challenge.

Objective: To map the nursing interventions used to control fatigue in people in palliative situations.

Methods: Scoping Review according to the Joanna Briggs Institute methodology. Two independent researchers performed the analysis, extraction and synthesis of the results.

Results: Nursing interventions such as Psychosocial Intervention, Aromatic Massage, Standard Palliative Care, Online Collaborative Intervention, Cognitive Behavioural Therapy, Physical Exercise and acupuncture were identified.

Conclusion: The studies point to multidisciplinary multimodal interventions, where the nurse has a primary role. However, there are no studies in patients in a terminal phase of their disease, that is, in the last months or days of life, so further research is suggested on the effectiveness of interventions to control patient fatigue in palliative care and the adoption of strategies that improve the knowledge of health professionals about the impact of fatigue.

Keywords: palliative care; fatigue; nursing

RESUMEN

Introducción: La fatiga es uno de los síntomas más comunes en pacientes en cuidados paliativos que afecta su calidad de vida y cuyo manejo permanece un desafío.

Objetivo: Mapear las intervenciones de enfermería utilizadas para el control de la fatiga en personas en situaciones paliativas.

Métodos: Scoping Review según la metodología del Joanna Briggs Institute. Dos investigadores independientes realizaron el análisis, extracción y síntesis de los resultados.

Resultados: Se identificaron intervenciones de enfermería como Intervención Psicosocial, Masaje Aromático, Cuidados Paliativos Estándar, Intervención Colaborativa Online, Terapia Cognitivo-Conductual, Ejercicio Físico y Acupuntura.

Conclusión: Los estudios apuntan a intervenciones multidisciplinares multimodales, donde el enfermero tiene un papel primordial. Sin embargo, no existen estudios en pacientes en fase terminal de su enfermedad, es decir, en los últimos meses o días de vida, por lo que se sugiere profundizar en la investigación sobre la efectividad de las intervenciones para el control de la fatiga del paciente en cuidados paliativos y la adopción de estrategias que mejoran el conocimiento de los profesionales de la salud sobre el impacto de la fatiga.

Palabras Clave: cuidados paliativos; fatiga; enfermería

INTRODUÇÃO

De acordo com a *International Association for Hospice and Palliative Care* (Radbruch, et al., 2020, p.755), os Cuidados Paliativos são “cuidados holísticos, ativos, prestados a indivíduos de todas as idades com sofrimento intenso, decorrente de doença grave, especialmente dirigidos àqueles perto do fim de vida. Têm como objetivo melhorar a qualidade de vida das pessoas doentes, das suas famílias e cuidadores".

Os avanços nos tratamentos médicos para os doentes com doenças incuráveis conduziu a um prolongamento da sobrevida. Hoje, doentes com cancro incurável, sob terapêutica oncológica com intenção paliativa, podem permanecer num processo de doença crónica por um período de tempo com duração de anos (Poort et al., 2017, p.6).

De acordo com a *Australian National Sub-acute and Non-acute Patient*, uma doença terminal tem associada quatro fases paliativas, que são descritas e baseadas em características individuais do sofrimento apresentado por cada doente. Assim, as quatro fases paliativas, estão associadas ao estadio da doença, onde cada uma delas corresponde a diferente nível de complexidade: fase aguda, fase de deterioração, fase terminal e fase estável.

Para Radbruch et al. (2008) a fadiga é um dos sintomas mais comuns na pessoa em cuidados paliativos, afetando mais de 80% dos doentes. Para os autores, é descrita como uma sensação subjetiva em que se sente cansaço, fraqueza e falta de energia e que afeta a pessoa física, emocional e cognitivamente, não apenas o doente oncológico, mas também o doente com patologia não oncológica.

Segundo o *National Comprehensive Cancer Network* (NCCN) a fadiga relacionada com o cancro é "uma sensação angustiante, persistente e subjetiva de cansaço físico, emocional e / ou cognitivo ou exaustão relacionada com o cancro ou com o seu tratamento que não é proporcional à atividade recente e, interfere com o normal funcionamento (Berger, 2020, p.FT-1). Poort et al. (2017, p.3) acrescentam que a fadiga, além de um sintoma prevalente, é também um fator que afeta a qualidade de vida do doente.

No doente com cancro avançado, a fadiga está associada a uma multiplicidade de fatores como os sociodemográficos, clínicos (status funcional do doente e tratamento dirigido ao cancro), parâmetros biológicos (níveis séricos de hemoglobina e albumina) e ao descontrolo dos restantes sintomas físicos, como a dor ou a dispneia (Ghoshal et al., 2017).

Segundo Klasson, Frankling, Hagelin e Björkhem-bergman (2021, p.5) a etiologia da fadiga "pode diferir na fase paliativa inicial em comparação com a fase tardia. Na fase inicial, a fadiga e a mudança na fadiga costumam mostrar uma associação com biomarcadores de inflamação. No entanto, no estágio tardio, próximo à morte, uma melhoria na fadiga costuma ser difícil de alcançar e a recuperação dos biomarcadores inflamatórios raramente é possível. A experiência de fadiga nos últimos dias de vida também é influenciada por outros sintomas e pelo facto de que a vida chega ao fim. Apesar da mesma etiologia influente, a experiência e o significado da fadiga podem diferir no fim da vida em comparação com as fases paliativas anteriores". Desta forma, a fadiga é um sintoma cuja gestão permanece um desafio, não só pelo exposto, mas também pela sobreposição de outros sintomas específicos da doença, e pela falta de evidência da eficácia das intervenções no contexto dos cuidados paliativos (Ingham & Urban, 2020, p.59).

Para Ingham e Urban (2020), num estudo realizado na Austrália, cujo objetivo era compreender as atitudes dos profissionais de saúde de cuidados paliativos face à fadiga, verificaram que, a maioria dos participantes reconhecia a fadiga como um sintoma comum, associando-a a um percurso normal da doença incurável, não reconhecendo este sintoma quando severo, como potencialmente mais impactante do que a dor. No mesmo estudo, os autores verificaram, ainda, que os profissionais de saúde consideravam como consensuais as estratégias baseadas no exercício e na conservação de energia, e a intervenção dirigida às expectativas do doente no controlo da fadiga. Por outro lado, identificaram como barreiras, a falta de tempo e recursos, a baixa capacidade e motivação do doente que adota uma atitude de resignação perante a fadiga, fatores associados à doença como a coexistência de outros sintomas descontrolados, dificuldade em mensurar a fadiga por parte do doente, que confunde o nível do sintoma com o nível de sofrimento por ele causado e pelas opções terapêuticas limitadas (Ingham & Urban, 2020).

De acordo com a literatura, a gestão da fadiga "envolve uma estratégia multidimensional, dividida em estratégias farmacológicas e não farmacológicas" (Poort et al. 2017, p.6). Klasson, Frankling, Hagelin e Björkhem-bergman (2021, p.1) numa revisão narrativa das intervenções farmacológicas concluíram que "a evidência ainda é fraca para o uso de tratamentos farmacológicos na fadiga em doentes em cuidados paliativos, embora o metilfenidato e os corticosteroides possam ser considerados no seu tratamento".

Tendo em conta a pouca evidência acerca das intervenções de enfermagem que visam a melhoria da prestação de cuidados no controlo da fadiga, optou-se por realizar uma *scoping review* com o objetivo de mapear as intervenções de enfermagem utilizadas no controlo da fadiga na pessoa em situação paliativa. Este objetivo pretende dar resposta à questão de investigação: Quais as intervenções de enfermagem utilizadas no controlo da fadiga na pessoa em situação paliativa?

1. MÉTODOS

A investigação foi orientada de acordo com metodologia proposta pelo *Joanna Briggs Institute* (JBI) *for Scoping Reviews* (Peters et al., 2020). Foi desenvolvido um protocolo de investigação onde estavam definidos os critérios de inclusão, os limitadores, a questão de investigação, o limite temporal, a frase boleana, entre outros aspetos que de seguida se apresentam.

A questão teve por base o acrónimo PCC (*Population, Concept and Context*), onde a População correspondia a Doentes com fadiga, o Conceito às Intervenções para o controlo da fadiga e o Contexto, aos Cuidados Paliativos.

Definidos os termos da questão, os investigadores definiram como critérios de inclusão os estudos com Pessoa adulta em situação paliativa e Intervenções de enfermagem no controlo da fadiga. Os limitadores da pesquisa definidos pelos investigadores foram os artigos escritos em português, inglês ou espanhol e o limite temporal de 2016 a 2021.

Foram identificados os descritores DeCS/MeSH e CINAHL Headings e, elaborada a frase booleana:

> (TI (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH "Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices")) OR AB (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH "Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices"))) AND

(TI ((MH "fatigue") OR (MH "Asthenia") OR " symptom fatigue ") OR AB ((MH "fatigue") OR (MH "Asthenia") OR " symptom fatigue "))

A estratégia de pesquisa incluiu fontes de evidência tanto publicadas quanto não publicadas e compreendeu a três etapas. Na primeira etapa (6/03/2021) foi realizada a pesquisa nas bases de dados CINAHL Complete, MEDLINE Complete e Cochrane Central Register of Controlled Trials através do agregador de conteúdos EBSCOHost. Na segunda etapa (10/03/2021) foram replicados os termos de pesquisa na Scopus, no RCAAP (Repositórios Científicos de Acesso Aberto de Portugal disponível em https://www.rcaap.pt/) e no Google Académico. Na terceira etapa foram examinadas as referências bibliográficas dos artigos elegíveis por forma a identificar estudos adicionais.

Após a análise dos artigos elegíveis foi aplicado o limite temporal, pela redundância dos resultados. Os artigos foram analisados por dois investigadores independentes. Nas situações em que não houve consenso entre os investigadores, foi solicitada a avaliação por um terceiro investigador. Para gerir as referências bibliográficas recorreu-se aos softwares Rayyan e Mendeley.

Para a extração dos resultados, e de acordo com o JBI (2020), foi elaborado um instrumento com dados sobre os autores, ano de publicação, origem, objetivos do estudo, população e tamanho da amostra dentro da fonte de evidência (se aplicável), metodologia / métodos, tipo de intervenção, duração da intervenção (se aplicável) e resultados. Dois investigadores independentes realizaram a extração e síntese dos dados. As situações de incerteza foram resolvidas através de discussão com um terceiro investigador.

Dado que numa *scoping review* o objetivo é determinar que tipo de evidência está disponível, independentemente da qualidade, não se realizou a avaliação da qualidade metodológica dos estudos.

2. RESULTADOS

Os estudos foram analisados de acordo com o Diagrama PRISMA. A pesquisa efetuada, identificou 619 estudos com potencial relevância, tal como a figura 1 evidencia. Destes, 153 foram excluídos pelo facto de serem duplicados. Dos 466 registos analisados, 400 foram excluídos após ter sido avaliado o título e resumo e 46 por não cumprirem o limite temporal estipulado. Feita a avaliação foram selecionados 20 artigos que após leitura integral, levaram à exclusão de 5 artigos por contexto e 6 por conceito, uma vez que não cumpriam os critérios de inclusão. Por último, incluíram-se nesta revisão 9 artigos.

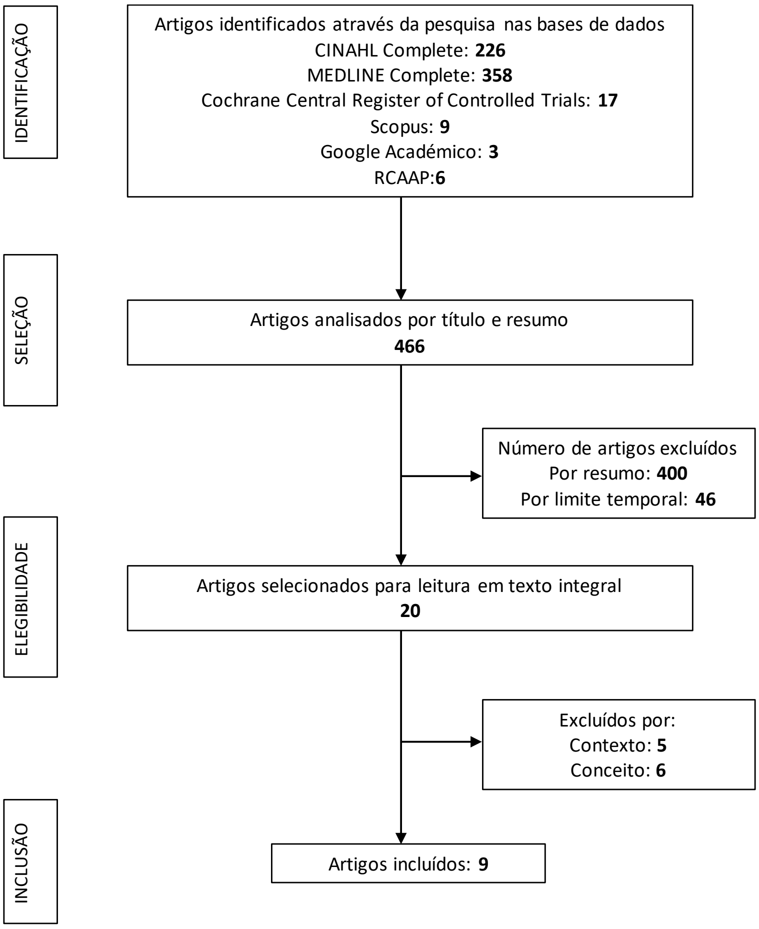

Figura 1 – Diagrama com seleção dos estudos segundo o PRISMA (PRISMA, 2009)

De seguida apresentam-se os nove artigos incluídos no estudo (tabela 1) e que fizeram parte do *corpus* de análise.

Tabela 1 – Estudos Incluídos na revisão

Estudos Incluídos
Poort, H., Peters, M. E. W. J., van der Graaf, W. T. A., Nieuwkerk, P. T., van de Wouw, A. J., Nijhuis-van der Sanden, M. W. G., Bleijenberg, G., Verhagen, C. A. H. H. V. M., & Knoop, H. (2020). Cognitive behavioral therapy or graded exercise therapy compared with usual care for severe fatigue in patients with advanced cancer during treatment: a randomized controlled trial.
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Tal como citado anteriormente para a extração dos resultados, e de acordo com o JBI (2020), foi elaborada uma tabela síntese dos artigos selecionados para análise de forma a apresentar os resultados e mapear o material revisto de forma lógica e descritiva (tabela 2).

Tabela 2 – Tabela síntese dos artigos selecionados para análise

Ano	Autores	Metodologia	Resultados
2020	Poort et al.	Estudo randomizado	A terapia cognitivo-comportamental reduziu a fadiga e melhorou a qualidade de vida e, a capacidade funcional, até 3 meses após a intervenção. Relativamente ao exercício físico, não houve redução estatisticamente significativa nos níveis de fadiga.
2019	Zuo, Wen, Gong & Meng	Revisão sistemática	A intervenção colaborativa através de uma equipa multidisciplinar composta por profissionais, doente e cuidador, mostrou ser uma intervenção benéfica no controlo da fadiga. A prestação de cuidados personalizados com base num protocolo, a psico-educação, que inclui intervenções como o relaxamento, a imaginação e a distração, os exercícios passivos com o doente sentado, assegurando um equilíbrio entre a atividade e o repouso, a intervenção cognitivo-comportamental e um programa *qigong*, que inclui treino da consciência corporal, relaxamento e massagem mostrou ter resultados positivos no controlo da fadiga e da força muscular no doente sob quimioterapia.
2019	Koesel, Tocchi, Burke, Yap & Harrison	Estudo pré e pós teste	Diminuição estatisticamente significativa nos scores de fadiga segundo a ESAS, após implementação das diretrizes de cuidados paliativos oncológicos da *American Society of Clinical Oncology* (ASCO) em consultas de cuidados paliativos.
2019	Miller, Patel, Symanowski, Edelen & Walsh	Estudo retrospetivo	Há uma melhoria estatisticamente significativa no controlo da fadiga após o primeiro tratamento com acupunctura e durante os restantes, sendo que a melhoria nos níveis da fadiga está correlacionada com a redução dos níveis de dor.
2017	Poort et al.	Revisão sistemática	Os resultados não suportam a efetividade das intervenções psicossociais na redução da fadiga.
2017	Ghoshal, Salins, Deodhar, Damani & Muckaden	Estudo retrospetivo observacional	O estudo evidenciou que a consultadoria em cuidados paliativos está associada a uma melhoria no controlo da fadiga no momento do primeiro *follow up* (2-4 semanas após a intervenção).
2017	Cheng et al.	Ensaio Clínico Randomizado	O nível de fadiga reduziu após 2 semanas, no grupo de participantes que recebeu acupuntura (8 sessões de 45 minutos, durante 4 semanas, 2 por semana) quando comparado com o que recebeu um tratamento placebo.
2016	Park, Chun, & Kwak	Estudo comparativo	Não encontraram diferenças estatisticamente significativas entre os grupos
2016	Steel et al.	Estudo randomizado	As intervenções de cuidado colaborativo envolvendo enfermeiros, médicos, psicólogos, doente e cuidador reduzem o stress, dor e fadiga e melhoram a qualidade de vida de doentes com cancro em estado avançado.

4. DISCUSSÃO

Atualmente, os Cuidados Paliativos são cada vez mais reconhecidos em Portugal, fazendo parte do Sistema Nacional de Saúde. A abordagem a esta questão, nos últimos anos, tem sido cada vez mais crescente devido, quer ao envelhecimento populacional quer ao aumento de condições de saúde mais complexas decorrentes da maior prevalência de neoplasias, doenças crónicas ou degenerativas. Os cuidados paliativos são centrados numa abordagem que visa a promoção da qualidade de vida da pessoa e dos seus familiares, através da correta avaliação e controle dos sintomas físicos, sociais, emocionais e espirituais que se desenvolvem no contexto da doença (OMS, 2002). Os cuidados são realizados por uma equipa multiprofissional durante o período do diagnóstico, doença, fim de vida e luto.

A abordagem Paliativa integra um conjunto de métodos e procedimentos que devem ser utilizados e que envolvem medidas farmacológicas e não farmacológicas para o controlo de sintomas no acompanhamento dos doentes. Apesar dos avanços nos últimos anos, a fadiga, relacionada com o cancro, é um sintoma subvalorizado, entendido como natural ao processo de doença e, portanto, subtratado.

Da análise dos artigos sobressai um conjunto de intervenções não farmacológicas consistentes, embora existam algumas evidências contraditórias.

É evidente que as pessoas com necessidades paliativas carecem de cuidados especializados prestados por equipas multidisciplinares próprias, com competências especializadas, focadas na otimização da sua qualidade de vida. Ghoshal et al. (2017), num estudo retrospetivo observacional que realizaram na Índia em 500 doentes com cancro avançado a quem implementaram cuidados paliativos standard e introduziram consultas de acompanhamento após a intervenção inicial, concluíram que os doentes com acompanhamento contínuo, através de consultas de *follow up* com periodicidade entre duas a quatro semanas após a intervenção, apresentaram melhoria no controlo da fadiga. Koesel et al. (2019) nos EUA, implementaram as diretrizes de cuidados paliativos oncológicos da *American Society of Clinical Oncology* (ASCO) com o objetivo de avaliar a diminuição dos sintomas, como a dor, a fadiga e a ansiedade, após a sua implementação em consultas de acompanhamento. Estudaram 31 doentes onde aplicaram a Escala de Avaliação de Sintomas de Edmonton (ESAS). Os scores da ESAS para a dor, a fadiga e a ansiedade foram medidos antes da consulta e em duas visitas subsequentes. Após a implementação das diretrizes, observaram uma diminuição estatisticamente significativa nos scores de fadiga segundo a ESAS nos três momentos.

Pela análise destes estudos verifica-se a importância da existência de acompanhamento por uma equipa que preste cuidados paliativos. Esta ideia é reforçada no estudo de Steel et al. (2016), estudo randomizado controlado realizado com 261 doentes com cancro em estado avançado e 179 cuidadores, onde examinaram a eficácia de uma intervenção de cuidado colaborativo. A equipa colaborativa de cuidados incluía enfermeiros, como coordenadores, médicos, psicólogos, o doente e o seu cuidador. O estudo demonstrou que o trabalho de uma equipa colaborativa reduz a depressão, a dor e a fadiga, e melhora a qualidade de vida do doente com cancro. No estudo a equipa monitorizou os sintomas via on-line ou telefonicamente. As intervenções incluíam educação, autogestão, registo em diário, uma sala de chat, uma biblioteca audiovisual e suporte de pares. A telemonitorização e as intervenções on-line, eram recomendadas para doentes com cancro avançado, reduzindo não só os sintomas da doença como também os custos dos cuidados de saúde.

Estes estudos evidenciam que a existência de equipas especializadas, treinadas e dedicadas que adotem uma intervenção colaborativa que envolva uma equipa multidisciplinar composta por médicos, enfermeiros, psicólogos, doente e familiares é fundamental para o controle da fadiga na pessoa em situação paliativa, particularmente se adotarem um conjunto de estratégias não farmacológicas.

Poort et al. (2017) numa revisão sistemática realizada que englobou 14 estudos randomizados mostrou que as intervenções psicossociais realizadas individualmente ou em grupo, por psicólogos ou enfermeiros, não se mostraram efetivas na redução da fadiga. Contudo em 2020 Poort et al., num estudo randomizado controlado realizado em 134 doentes com cancro localmente avançado ou metastizado, com fadiga severa e com expectativa de vida superior a seis meses submetidos a terapia cognitivo-comportamental, obtiveram redução da fadiga e melhoria da qualidade de vida e da capacidade funcional quando comparados com o grupo que recebeu cuidados habituais (grupo controle). Estes dois resultados embora controversos levam a pensar que a terapia cognitivo-comportamental pode ter um papel importante na redução da fadiga. Apesar do estudo de Poort et al. (2020) também englobar o exercício físico, os autores concluíram que este não produziu redução estatisticamente significativa nos níveis de fadiga.

Ingham e Urban (2020) acrescentam que tanto o exercício físico como a terapia cognitivo-comportamental são duas intervenções com evidência elevada no controle da fadiga. No entanto, faltam estudos que identifiquem quais os exercícios recomendados e a sua relação com o estadiamento da doença. Estudos realizados, não em contexto de cuidados paliativos, apontam para exercícios de força/resistência e exercícios aeróbicos.

Relativamente à intervenção colaborativa de uma equipa multidisciplinar centrada na prestação de cuidados personalizados com base em protocolos, existem vários estudos que descriminam um conjunto de intervenções não farmacológicas com resultados efetivos no controlo da fadiga. Zuo, Wena, Gongb e Mengb (2019) na sua revisão sistemática que envolveu seis estudos randomizados com 736 doentes adultos com cancro avançado, submetidos a intervenções não farmacológicas dirigidas por enfermeiros, identificaram como intervenções benéficas no controlo da fadiga: o relaxamento, a imaginação guiada e a distração, os exercícios passivos com o doente sentado, assegurando um equilíbrio entre a atividade e o repouso, a intervenção cognitivo-comportamental, a acupunctura e um programa *qigong*, que incluía treino da consciência corporal, relaxamento e massagem. Todas as intervenções mostraram ter resultados positivos no controlo da fadiga e na força muscular no doente sob quimioterapia. Cheng et al. (2017), realizaram um ensaio clínico randomizado com 28 doentes com diagnóstico de carcinoma de pequenas células do pulmão, sob quimioterapia e radioterapia com fadiga e verificaram que o nível de fadiga reduziu após duas semanas no grupo de participantes que recebeu sessões de acupuntura quando comparado com o grupo que recebeu tratamento placebo. Miller et al. (2019), num estudo retrospetivo de todos os processos de doentes referenciados no *Levine Cancer Institute Section of Palliative Medicine*, submetidos a acupunctura para o tratamento da dor e outros sintomas, concluíram que houve uma melhoria estatisticamente significativa no controlo da fadiga após a primeira sessão de acupunctura e durante as restantes, sendo que a melhoria nos níveis da fadiga estava correlacionada com a redução dos níveis de dor.

Park et al. (2016) na Coreia do Sul, compararam os efeitos da intervenção da massagem, com e sem aromoterapia, com o objetivo de perceber a sua influência no nível de fadiga e sono dos doentes em unidades de cuidados paliativos numa amostra de 30 doentes, contudo não encontraram diferenças estatisticamente significativas entre os grupos.

Embora algumas intervenções não farmacológicas em alguns estudos não tenham demonstrado diferenças estatisticamente significativas, a maioria permite concluir que existe um conjunto de intervenções não farmacológicas como: relaxamento, distração, imaginação guiada, exercícios passivos, intervenção cognitivo-comportamental, acupunctura e massagem com ou sem aromoterapia, que produzem efeitos no controlo da fadiga na pessoa em situação paliativa.

CONCLUSÃO

O estudo permitiu verificar que as intervenções consensuais passam por uma intervenção multidisciplinar multimodal, onde o enfermeiro tem um papel primordial, incluindo intervenções no âmbito do exercício físico individual conciliado com estratégias de conservação de energia (exercícios passivos), educação e aconselhamento (higiene do sono e alimentação) e terapia cognitivo-comportamental. Existe também um conjunto de intervenções não farmacológicas integradas numa intervenção colaborativa de uma equipa multidisciplinar como a massagem, a acupunctura, o relaxamento, a distração ou a imaginação guiada que reduzem o efeito da fadiga. Verifica-se também que as intervenções no âmbito dos cuidados paliativos, onde a filosofia se foca no doente e família no centro dos cuidados, no controlo sintomático, na comunicação e no trabalho em equipa, evidenciam resultados positivos no controlo da fadiga. De igual forma, na pessoa em situação paliativa, onde o objetivo passa por proporcionar o máximo de conforto, é necessário equilibrar o impacto da fadiga com intervenções dirigidas.

Conclui-se que os estudos incluem pessoas em diferentes fases da sua doença, nomeadamente doentes oncológicos sob terapêutica curativa, doentes sobreviventes ao cancro e doentes numa fase paliativa. No entanto não há estudos em doentes numa fase terminal da sua doença, ou seja, nos últimos meses ou dias de vida. Pelo exposto, sugerem-se novas investigações sobre a eficácia das intervenções no controlo da fadiga em doentes em cuidados paliativos nessa fase da doença.

IMPLICAÇÕES PARA A PRÁTICA

Este estudo realça que para o controle da fadiga na pessoa em Cuidados Paliativos é fundamental uma intervenção multidisciplinar multimodal, que envolva uma equipa de profissionais com competências diversificadas que atuem em complementaridade adotando um plano de tratamento que envolva intervenções farmacológicas e não farmacológicas.

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INTERVENÇÕES NO CONTROLO DA XEROSTOMIA NA PESSOA EM SITUAÇÃO PALIATIVA – SCOPING REVIEW

INTERVENTIONS IN THE CONTROL OF XEROSTOMIA IN THE PERSON IN PALLIATIVE SITUATION – SCOPING REVIEW

INTERVENCIONES EN EL CONTROL DE LA XEROSTOMIA EN PERSONA EN SITUACIÓN PALIATIVA - REVISIÓN DE ALCANCE

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RESUMO

Introdução: Xerostomia é a sensação subjetiva de boca seca, ocorre quando menos saliva é segregada do que a quantidade de água perdida por evaporação e por absorção da mucosa oral. Tem múltiplas consequências para a saúde geral e oral das pessoas em situação paliativa, bem como para a qualidade de vida.
Objetivo: Objetivos: Examinar e mapear as intervenções implementadas para aliviar a xerostomia da pessoa em situação paliativa.
Métodos: Scoping review de acordo com as etapas previstas pelo Joanna Briggs Institute. As bases de dados utilizadas para pesquisa foram: CINAHL COMPLETE®, PUBMED®, MEDLINE COMPLETE®, SCOPUS® e SciELO®.
Resultados: Identificados 707 artigos e incluídos 19 na análise final. Esta revisão, considerou os estudos focados em pessoas com doença crónica avançada e irreversível, em situação paliativa e fim de vida, com 18 anos ou mais. As intervenções para o controlo da xerostomia são do tipo: não farmacológicas, avaliação da cavidade oral, acupuntura, substitutos da saliva, estimulantes da saliva e programas educação de higiene oral; e farmacológicas, os parassimpaticomiméticos: pilocarpina e cloreto de betanecol.
Conclusão: A xerostomia é uma condição de saúde que pode causar constrangimento social e desconforto crónico, com grande impacto na qualidade de vida das pessoas. Agrupar as evidências disponíveis, dentro desta temática, pode contribuir para que os profissionais de saúde as incorporem na prática assistencial, contribuindo para um aumento da qualidade de vida da pessoa e alívio do sofrimento.

Palavras-chave: xerostomia; boca seca; cuidados paliativos; intervenções

ABSTRACT

Introduction: Xerostomia is the subjective sensation of dry mouth; it occurs when less saliva is secreted than the amount of water lost through evaporation and absorption from the oral mucosa. It has multiple consequences for the general and oral health of people in a palliative situation, and quality of life.
Objective: To examine and map the interventions implemented to relieve xerostomia of the person in palliative situation.
Methods: A scoping review was conducted following the Joanna Briggs Institute methodology. Data search was performed in the following databases: CINAHL COMPLETE®, PUBMED®, MEDLINE COMPLETE®, SCOPUS® and SciELO®.
Results: A total of 707 articles were identified, and 19 were extracted for final analysis. This scoping review considered the studies focused on people with advanced and irreversible chronic disease, in a palliative situation and at the end of life, aged 18 years or more. Interventions for the control of xerostomia are: non-pharmacological, assessment of the oral cavity, acupuncture, saliva substitutes, saliva stimulants and oral hygiene education programmes; pharmacological parasympathomimetic: pilocarpine and bethanechol chloride.
Conclusion: Xerostomia is a health condition that can cause social embarrassment and chronic discomfort, with a great impact on people's quality of life. Grouping the available evidence, within this theme, can help health professionals to incorporate it into care practice, contributing to the increase in the person's quality of life and the relief of suffering.

Keywords: xerostomia; dry mouth; palliative care; interventions

RESUMEN

Introducción: La xerostomía es la sensación subjetiva de boca seca, ocurre cuando se secreta menos saliva que la cantidad de agua perdida por evaporación y absorción de la mucosa ora. Tiene múltiples consecuencias para la salud general y bucal de las personas en situaciones paliativas, y calidad de vida.
Objetivo: Examinar y mapear las intervenciones implementadas para aliviar la xerostomia de la persona en condiciones paliativas.
Métodos: Revisión del alcance de acuerdo con los pasos proporcionados por el Instituto Joanna Briggs. Las bases de datos para la investigación fueron: CINAHL COMPLETE®, PUBMED®, MEDLINE COMPLETE®, SCOPUS® y SciELO®
Resultados: Se identificaron 707 artículos, 19 de ellos para el análisis final. Esta revisión consideró los estudios centrados en personas con enfermedad crónica avanzada e irreversible, en situación paliativa y al final de la vida, de 18 años más. Las intervenciones para el control de la xerostomía son: no farmacológicas, evaluación de la cavidad oral, acupuntura, sustitutos de la saliva, estimulantes de la saliva y programas de educación en higiene bucal; parasimpaticomiméticos farmacológicos: pilocarpina y cloruro de betanecol.
Conclusión: La xerostomía es una condición de salud que puede causar vergüenza social y malestar crónico, con un gran impacto en la calidad de vida de las personas. Agrupar la evidencia disponible, dentro de esta temática, puede ayudar a los profesionales de la salud a incorporarla a la práctica asistencial, contribuyendo al aumento de la calidad de vida de la persona y al alivio del sufrimiento.

Palabras Clave: xerostomía; boca seca; cuidados paliativos; intervenciones

INTRODUCTION

According to the Worldwide Hospice Palliative Care Alliance (WHPCA), palliative care is a health policy priority. It is health care, coordinated and global. Its main objective is to promote the quality of life, the development of human well-being and maximize the dignity of care. They help the person with an advanced and incurable chronic illness to live and reduce suffering in extreme end-of-life circumstances. They promote person- and family-centred care. They are provided by multidisciplinary units and teams and in inpatient units or at home (WHO, 2014). It promotes the relief of pain and other disruptive symptoms, affirms life and views death as a natural process. Palliative care integrates the psychological and spiritual aspects of the person in the care process, helping the patient to live as actively as possible until death. They use a multidisciplinary approach to meet the needs of the person and family, including follow-up in bereavement. They encourage quality of life and positively impact the course of the disease, with an early intervention and a systematic assessment of the person in a palliative situation. That combines treatments that aim to prolong life, and when needed, exams to better understand and treat the person's problems (WHPCA, 2020). The strict control of the various symptoms that the person in a palliative situation presents is one of the supporting pillars of palliative care. This is ensured by the rigorous assessment of the symptoms' triggering effects (Twycross, 2020). Xerostomia is the subjective sensation of dry mouth reported by patients. It is considered a symptom of various pathologies, and may also be a consequence of treatments and changes in salivary gland function (De Luca & Roselló, 2014). Xerostomia, is illustrated in the literature as a triggering factor of changes and transformations at various levels (Mercadante et al., 2015). The impact of this problem on the person in a palliative situation interferes with the physical, psychological, emotional and social capacities, conditioning quality of life and even dignity (Fischer et al., 2014). The prevalence of xerostomia ranges from 78% to 88%, being one of the most frequent patients reported symptoms (Lourenço, 2017). Xerostomia is the third most frequent symptom in palliative care, when excluding pain (Al-Shahri et al., 2012). It has a multifactorial aetiology and sometimes it is a very complex symptom to resolve. Identifying it makes it important to assess the oral cavity, use appropriate diagnostic tools and apply effective therapeutic approaches (Al-Shahri et al., 2012). Aetiological factors can be divided into four major groups: iatrogenic, organic diseases, functional causes and psychogenic causes. The iatrogenic causes include head and neck radiotherapy, the use of cytostatics, bone marrow transplantation, smoking, alcohol consumption and the use of drugs (Plemons et al., 2014). With regard to the causes of organic origin, there are also multiple situations that are conducive to the existence of xerostomia, among which rheumatoid arthritis, systemic lupus erythematosus, scleroderma type 1 and 2 diabetes mellitus, sarcoidosis, HIV, primary biliary cirrhosis, hepatitis C, thyroid diseases, amyloidosis, iron accumulation diseases (thalassaemia), infectious diseases (parotitis), cystic fibrosis, among others (Montgomery-Cranny et al., 2014; Mortazavi et al., 2014). Functional causes are also relevant, such as dehydration or inadequate fluid intake, diarrhoea and persistent vomiting, protein deficiencies, cardiac disorders, oedema and malnutrition (De Luca, & Roselló, 2014). The aetiology of xerostomia should also include other physiological causes, mouth breathing, and psychological causes, such as anxiety, stress and depression, which are also triggering factors of this symptom (Montgomery-Cranny et al., 2014). The decrease in the quantity and quality of saliva predisposes to the appearance of lesions of varying severity in the mouth. Due to their difficulty in speaking, halitosis and pain due to dry mucous membranes, patients often avoid social contacts and many of them isolate themselves, which negatively interferes with their quality of life. The mouth is an important and complex organ of the body, with physiological and psychological significance, which allows people to interact between their inner and outer worlds. It is through the mouth that we can perform some of the most important functions of our entire existence, such as eating or verbal communication. Caring for the patient's mouth is a basic intervention of health professionals, especially nurses. They are responsible for managing the aspects related to the provision of this type of care, either directly by providing oral care, or indirectly through the teaching provided to patients and families, or the promotion of self-care. Caring for the mouth of the person in a palliative situation requires various skills which include assessing the condition of the mouth, early recognition of changes, and planning and implementing interventions aimed at solving and/or minimising these problems. This care goes beyond the physical dimension. It can be considered a global care that seeks, together with all other interventions, to promote the dignity of the person in need of palliative care through unconditional respect. Nevertheless, evidence shows that although nurses, for example, recognize the importance of the person's oral cavity care in a palliative situation, they attribute little relevance to it, underlying the lack of knowledge about the subject (Lourenço, 2017). This scoping review was guided by the methodology proposed by the Joanna Briggs Institute (JBI) for scoping review assessments (Peters, et al., 2020). In this respect, and as recommended by the JBI, preliminary research on MEDLINE, CINAHL and the JBI Database of Systematic Reviews and Implementation Reports, was conducted, allowing to verify that there was no scoping review record on the subject. The main objective was to systematically examine and map the research conducted on the interventions used to control xerostomia in palliative care. The reason is that xerostomia is described as a symptom, which is uncomfortable and implies various changes in the quality of life of patients, and because of that, it is imperative to map the existing evidences on the subject, thus giving the possibility of knowledge and understanding to health professionals who want to make a difference in intervening effectively in symptomatology relief. This mapping also allows us to identify relevant questions that help advance the evidence-based health system, increase knowledge, identify gaps, and inform systematic reviews.

1. METHODS

The research is orientated by the methodology proposed by the JBI for the Scoping Revision (Peters, et al., 2020It was written, based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Systematic Review Protocols- Scoping Reviews Extension (PRISMA-ScR) (Tricco et al., 2018). A research protocol was developed with inclusion and exclusion criteria, related to the review and revision issue, and the research limiters.

Review question/objectives: More specifically, the revision was guided by the following questions:

> i-What are the used interventions in the xerostomia control of the patient in a palliative situation?
> ii-What are the characteristics (intervention and duration type) of those interventions?
> iii-What is the specific health professional area that performs those interventions?

1.1 Inclusion criteria

As for the participants, this scoping review considered studies focused on patients with advanced and irreversible disease and in palliative situations aged 18 years or older. A person in a palliative situation, due to incurability and disease progression, is subject to physical, psychological and social suffering as well as spiritual (WHPCA, 2020).

Concept: This scoping review considered the studies that address the implemented interventions on controlling xerostomia, dry mouth and salivary gland dysfunction. It was considered non-pharmacological and pharmacological interventions.

1.2 Context

This review considered the studies that address the interventions for the xerostomia control in the context of advanced chronic disease and/or palliative and end-of-life care.

Sources: This scoping review considered quantitative studies and systematic reviews. Included quantitative studies are experimental (including controlled randomized trials or quasi-experimental studies) as well as observational designs (cohort and cross-sectional studies).

1.3 Research strategy

A three-stage search strategy was used. An initial search limited to MEDLINE Complete®; CINALH Complete®, PUBMED, SCOPUS. This is followed by an analysis of subject words contained in the title, in the abstract and, in index terms used to describe the articles. In the second stage, the search was replicated, using keywords and subject descriptors identified. In the third stage were examined the bibliographic references of the eligible articles so that it was possible to identify the additional studies. Included in this review were published studies in English and Portuguese regardless of the year of publication. The Mendeley software was used to manage the bibliographic references. The search was made through a Boolean language and by Boolean operators as AND (conjunction) and OR (disjunction) for the descriptors combination. According to the same language and, following mathematical logic, it was also used parentheses (to indicate which part of the research should be carried out first) and inverted commas (to indicate compound terms). The search was conducted in 26 February 2021. The Boolean sentences used on the research were: TI (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH" Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices")) OR AB (((MH "Hospice and Palliative Nursing")) OR (MH "Palliative Care") OR (MH "Terminally Ill Patients") OR "end-of-life care" OR "Palliative Medicine" OR ((MH "Hospice and Palliative Nurses Association")) OR (MH "Hospice Care") OR (MH "Terminal Care") OR "Palliative" OR "end of life" OR (MH "Hospices"))) AND (TI ((MH "Xerostomia") OR "dry mouth" OR "Salivary Flow" OR "Oral dryness") OR AB ((MH "Xerostomia") OR "dry mouth" OR "Salivary Flow" OR "Oral dryness"));

1.4 Study selection and data extraction

The study selection and data extraction were carried out by two independent authors and the possible differences between them were solved by consensus by a third author with the aim of confirming the eligibility of publications. To facilitate the process, the Rayyan QCRI® (Web Systematic Reviews) platform was used in the first stages of publication selection.

2. RESULTS

The full text articles were read and analysed by three independent researchers. About 19 articles met the inclusion criteria. The study selection process is according to the PRISMA diagram and is represented in Fig.1 (available at http://prismastatement.org/prismastatement/flowdiagram.aspx)

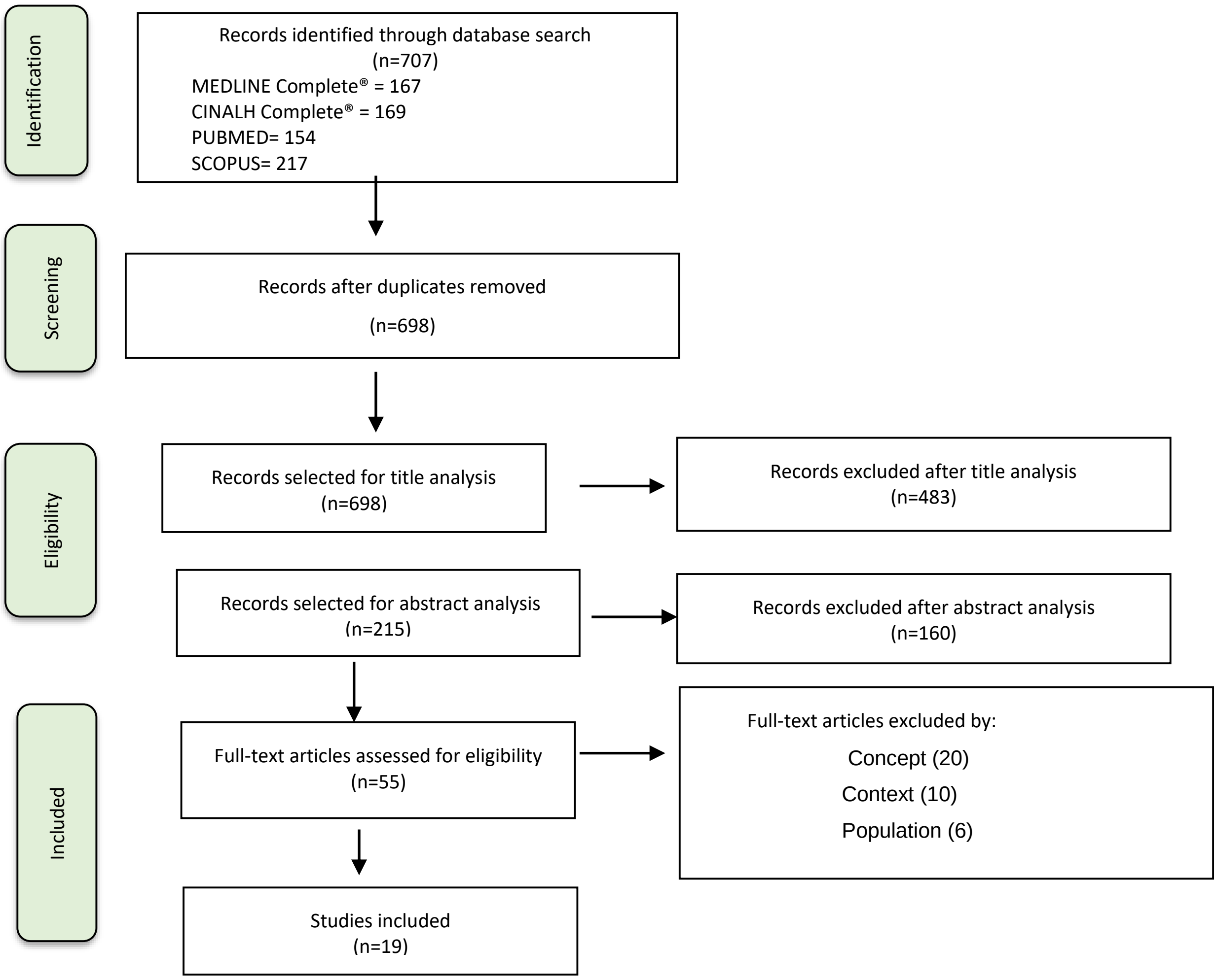

Figure 1 - PRISMA flowchart of the study selection and inclusion process (according Moher, 2009)

The extracted data from the 19 included studies for this revision were organized in two charts according to JBI (2020). The included study information was summarized, regarding the authors, year of publication, originating country, subject study, study design/method, and number of participants on table 1. In table 2 it is possible to see the intervention type used, professional group that used the intervention, duration time, and main results. To facilitate the presentation and results analysis, the studies were coded from E1 to E19. Of nineteen studies included in this review, seven are primary studies (S4, S5, S7, S10, S14, S17, S18) and twelve are literature reviews (S1, S2, S3, S6, S8, S9, S11, S12, S13, S15, S16, S19). The publication year of the studies included in this review range from 1997 to 2020. Most included studies were from the United States (S5, S8, S11, S13, S15, S16, S18) and the United Kingdom (S1, S2, S6, S9, S10, S19). The other articles are from the north of Europe: The Netherlands (3), Sweden (4), Norway (7). Finally, it included an article from Brunei (southeast of Asia, E12).

Table 1 - Characteristics of studies in the scoping review

Code	Author	Country	Study objective	Study design	Participants N
S1	Towler et al., 2013	United Kingdom	Assess the evidence of using acupuncture in the symptomatic control in a patient with cancer and with supportive care as well as to identify recommendations for clinical practice and future investigation.	Integrative review of reviews	403 patients with xerostomia

Code	Author	Country	Study objective	Study design	Participants N
S2	Davies & Hall, 2011	England	Review evidences of the clinical utility of used strategies on dysfunction management in salivary glands of patients with advanced cancer.	Integrative literature review	Patients with advanced cancer
S3	Nieuw Amerongen & Veerman, 2003	The Netherlands	Identify methods used to relieve the xerostomia symptoms involving stimulation of the residual salivary gland activity	Literature review	Patients with salivary gland hypofunction
S4	Meidell & Holritz Rasmussen, 2009	Sweden	To investigate if the acupuncture treatment is a viable option for a patient with xerostomia in an end-of-life situation.	Experimental study	117 patients with xerostomia: 67 within the inclusion criteria in the study, 14 were included, but only 8 finished the study
S5	Lopez et al., 2018	USA	To expand the ambulatory acupuncture effects on the symptoms reported by patients with advanced oncologic disease.	Retrospective analysis	375 patients with oncologic disease
S6	Davies et al., 2010	England	Analyse management strategies in the salivary gland dysfunction in patients with oncologic disease.	A systematic literature review	n/e
S7	Kvalheim et al., 2019	Norway	To study the efficiency of three different oral moisturizers in patients with palliative care needs: an aqueous solution of glycerol by 17%; the oxygenated glycerol triester and the Salient.	A randomized clinical trial	30 individuals per product
S8	Barford & D'Olimpio, 2008	USA	To incorporate current evidence and formulate efficient strategies to optimize results in common oncological symptoms as xerostomia.	Literature review	n/e
S9	Sheehy, L., 2013	United Kingdom	To present a general view of xerostomia and identify the objectives and assess oral hygiene and oral hygiene measures in end-of-life and palliative care.	Literature review	n/e
S10	Davies, A. N., 2000	United Kingdom (Sutton)	To compare the efficiency of artificial saliva from mucin (Saliva Orthana ™) with chewing gum without sugar and low adhesion.	Randomized, prospective, opened and cross-reference study.	43 patients with advanced cancer
S11	Kahn & Johnstone, 2005	The United States (New York)	Description of therapies used in the preservation of the salivary glands function in patients submitted to radiotherapy to head and neck tumours.	Literature review	n/e
S12	Venkatasalu et al., 2020	Brunei	To summarize published evidence about the oral conditions of patients in palliative care and its impact, management and the challenges on the treatment of those conditions.	Systematic review	19 primary sources focused on palliative patients and their oral conditions.

Code	Author	Country	Study objective	Study design	Participants N
S13	Moore & Guggenheimer, 2008	USA	To describe the normal salivary function: the potential salivary dysfunction causes; oral problems related to hyposalivation and diagnosis tests as well as patient care options.	Literature review	n/e
S14	Sweeney et al., 1997	Scotland	To analyse the therapeutic effect of the Saliva Orthana spray compared with a placebo spray without mucin.	The clinical trial was a controlled single-phase double-blind project.	35 patients with dry mouth assisted in a day care unity or inpatient care.
S15	Reisfield et al., 2009	USA	Describe the factors and effects of xerostomia.	Descriptive study	n/e
S16	Dahlin C. et al., 2006	USA	To analyse the distressing symptoms of patients with advanced and progressive disease. An example of those symptoms are: nausea, vomiting, cold, diarrhea, constipation as well as dyspnoea, dysphagia, hiccups, xerostomia, dysgeusia and fatigue.	Review study	n/e
S17	Mercadante S. et al., 2000	Italy	To determine the role of pilocarpine in xerostomia reduction due to the used opioid	Open and prospective study. Inpatient or home care.	N=19 patients with advanced cancer, hepatic/renal/ oropharyngeal disease
S18	Crogan, N.L., 2015	USA	To describe an improvement programme for xerostomia induced by medicine and to improve the food ingestion among senior people in nursing homes.	Experimental study using a pre-post design.	39 residents of elderly nursing homes that are cognitively intact from two different sites.
S19	Davies, A.N., 1997	UK	Identify strategies for the symptomatic management of xerostomia.	Literature review	n/e

On table 2 the summary about the data extracted from the analysed studies is continued. The main results and the details were stressed out as well as the main discoveries related to the revision matters.

Table 2 - Characteristics of studies in the scoping review (continuation)

Code	Type of interventions	Professional group using the intervention	Intervention time	Outcome:
S1	Acupuncture	Not mentioned	Not mentioned	The acupuncture benefit was verified in patients with xerostomia related to radiation. Multicentric studies are necessary to ensure sample size
S2	Non-pharmacological: Saliva stimulants: chewing gum with sugar; organic ingredients such as ascorbic acid, citric acid, and malic acid; acupuncture; Saliva substitutes: water. Pharmacological*:* parasympathomimetic (pilocarpine, bethanechol chloride, distigmine ;piridostigmina); artificial saliva.	Physicians and nurses	Not mentioned	The xerostomia management should be individualized and the priority should be the cause of treatment. Saliva stimulants are recommended in favour of their substitutes. Using chewing gum without sugar should be prioritized

Code	Type of interventions	Professional group using the intervention	Intervention time	Outcome:
S3	Non-pharmacological: Use of gustatory stimuli, with chewing gum; vitamin C tablets. Commercial or homemade elixirs (saline solution, bicarbonate and lemon).Saliva substitute, Diet (acidic fruits, cold cucumber or tomato slices or cold apple slices; cold drinks) Acupuncture as an additional therapy. Pharmacological: use parasympathomimetic (pilocarpine or cevimeline).	Dentists	Not mentioned	Radiotherapy treatment and head and neck oncological disease are the most common causes of salivary gland hypofunction. The saliva flow can be activated through mechanical or pharmacological stimulation of the salivary glands. The sore and damaged oral mucosa can be treated, softened and lubricated with mouthwash and gel ointment Oral palliative care for patients with xerostomia when saliva discharge is impossible or very low and supportive therapy when the salivary gland can be stimulated.
S4	10 acupuncture treatments were realized. The effect was measured by the analogical visual scale and by measurement of saliva production before and after the treatment (Navazesh and Christensen method,1982).	Nurse with experience in acupuncture	10 acupuncture treatments for 5 weeks (2x/week). For 2 years (2004-2006)	Patients experienced dry mouth relief, mainly after the 4th or 5th treatment. The authors recommend studies with larger samples.
S5	Acupuncture	Acupuncturist	Average number of treatments were 4 and 6 for a total of 1728 treatments from January to December of 2016.	Response clinical rates were higher than 50% to nausea, lack of air, well-being, spiritual pain, heat wave, numbness and, xerostomia. In the first follow-up a statistically significant improvement was observed in the researched symptoms.
S6	Non-Pharmacological: use of saliva stimulants and saliva substitutes: chewing gum without sugar, organic acids (ascorbic acid, citric acid). Acupuncture, electrostimulation. Daily hygiene. Pharmacological: parasympathomimetic (eg pilocarpine hydrochloride, bethanechol chloride, anetholetrithione and yohimbine).	Oncological health professionals in palliative care and odontology.		To prevent the salivary gland dysfunction induced by radiation. The salivary gland dysfunction treatment should be individualized. To consider treatment of the cause or causes of salivary gland dysfunction and the proper saliva stimulant. More knowledge about the salivary gland dysfunction related to cancer. Sugar drinks and foods should be avoided as well as acid medicine. Oral hygiene products with alcohol should be avoided. Regular dental revision should be done.
S7	Aequasyal was sprayed on the mucosa; the glycerol was applied with a soaked gauze and the Salient was dispensed to the patient by a spoon.	Dentists	The total time of the intervention was 3 days. The study was carried out from 1 march 2018 to 30 November 2018.	None of the three tested products were considered adequate. The 17% glycerol concentration had the most positive effect immediately after the application but less or no effect 2 hours after. Aequasyal and Salient had a long-lasting effect, but they were not preferred by patients. There is the need and necessity for better products and more research. The glycerol solution was preferred by that group of patients and the short time effect could be balanced with frequent applications.
S8	Recently, a supersaturated solution of calcium and phosphorus was approved for the usage in mucositis and xerostomia in patients undergoing chemoradiation.	Dentists		Xerostomia may be the result of polypharmacy. Cancer patients should undergo dental treatment before undergoing chemotherapy treatment. Using antihistamines, antidepressants and diuretics should be considered before starting chemotherapy.
S9	Non-pharmacological; Introduction of educational programmes on the importance of oral hygiene. Use as indicated: foam sticks for comfort measures; hydrogen peroxide; sodium bicarbonate; chlorhexidine, chewing gum; malic acid, vitamin C, and spray gel; topical use of petroleum-based products. Acupuncture; and family involvement. Review prescribed medication.	Nurses	n/e	Xerostomia is the third most frequent symptom in palliative care, when excluding pain (Al-Shahri et al., 2012). Patients have related this symptom as distressing. The guarantee of oral care in end-of-life patients can have a major physical, social and psychological well-being impact. Adequate training of nurses, enhances good practices and improves xerostomia management.

Code	Type of interventions	Professional group using the intervention	Intervention time	Outcome:
	Oral assessment of the client on admission and at regular intervals.			
S10	Using artificial saliva via spray before breakfast, before lunch, before dinner and before sleep time. Chewing the gum before breakfast, before lunch, before dinner and before sleep time.	n/e	Each patient received 5 days of treatment for each product with a 2-day break in changing between products.	Both artificial saliva and gum are efficient in xerostomia management. 68% of patients preferred chewing gum over the artificial saliva.
S11	Non-pharmacological: acupuncture; tap water with saline solution; bicarbonate solutions; mouthwashes; saliva substitutes; sugar-free tablets or gum. Pharmacological: amifostine; pilocarpine hydrochloride; Cevimeline (Evoxac), intravenous. Surgery to transfer the submandibular gland to the submental space.		Before, during and after radiotherapy	Amifostine leads to reduction of acute and chronic xerostomia after radiotherapy. Little consistent results regarding the use of pilocarpine. Xerostomia was avoided in 83% of patients in the surgical group. Acupuncture in study.
S12	Non-pharmacological: acupuncture; lubrication of the lips, mucosa with salivary substitutes and oral hygiene. Medical treatments. Dentists collaboration in the palliative care team.	Nurses and Dentists	Standard oral hygiene	Oral hygiene: it has improved dry mouth in patients by 80% or more. Challenges: Lack of knowledge by the health professionals and lack of collaboration by the patient.
S13	Non-pharmacological: avoid alcohol beverages, avoid mouthwash containing alcohol; use humidifiers; use salivary flow stimulants. Pharmacological: use of alternative medicine.	Dental medicine		Management of xerostomia through using alternative medicines; avoid alcoholic beverages, avoid mouthwashes containing alcohol; use humidifiers at night; use salivary flow stimulants. Saliva substitutes/lubricants are most useful when used just before bedtime or talking. Complications of xerostomia: dental caries and candidiasis. Diagnostic tests with yes and no questions were used for evaluation.
S14	Supplied Saliva Orthana oral spray, containing sodium fluoride and mucin as well as the placebo containing the same constituents but without mucin. Xerostomia with analogue scales to assess saliva production.	Dentists	They were accessed after 7 and 14 days,	There were no substantial differences between the two groups of patients regarding visual analogue scales of symptoms and the clinical picture. The classification of xerostomia, without any statistical scope. Both the active and placebo sprays alleviated oral dryness for many of the participants. Overall, the results indicate an important beneficial effect of oral sprays in controlling xerostomia in cancer patients.
S15	Non-pharmacological: review the therapy; stimulate residual gland function; saliva substitutes; stimulate oral hydration and optimize oral hygiene.			Aetiology, due to medication use and anticholinergic activity, head and neck radiotherapy, psychiatric comorbidities such as mood and anxiety disorders, and dehydration. Treatment: eliminate unnecessary drugs and/or titrate the possibility of modifying the dosage; stimulate residual gland function; saliva substitutes; stimulate oral hydration, and optimize oral hygiene.
S16	Non-pharmacological: Dietary changes that include avoiding sugars, spicy foods, sometimes salt, and dry or spicy foods. Moisten the food with fluids. Pharmacological interventions include pilocarpine, 5 mg orally three times daily; bethanechol, 25 mg three times daily and management of symptoms other than pain. Daily; methacholine, 10 mg daily; or cevimeline spray or mouthwash.			Xerostomia is experienced usually by patients in palliative care. It results from reduced salivary secretion, mouth erosion, local or systemic dehydration, and various mental illnesses. Assessment reveals thick, sticky, or absent saliva.

Code	Type of interventions	Professional group using the intervention	Intervention time	Outcome:
S17	Pharmacological interventions: All patients were treated with pilocarpine (eye drops, 2% solution) 5 mg orally.	Health professionals	Three times a day during one week.	Xerostomia can cause difficulty speaking, swallowing, and dysgeusia. It may be a symptom of systemic disease, an adverse effect of treatment with anticholinergic, antiadrenergic or cytotoxic drugs, or due to local radiotherapy. Opioid use is strongly associated with xerostomia. However, in this case there was no significant correlation between opioid dose and xerostomia. Xerostomia occurred in patients who discontinued pilocarpine. Polycarpine was well tolerated.
S18	Participants were given a small amount of lemon ice cream without sugar before meals for 6 weeks. For comparison, before the intervention, participants during the initial 6 weeks, drank 2 glasses of non-citrus beverage before meals.	Nurses	Six weeks	Statistically significant improvements were found in the food intake of the intervention target inpatients without any modification to existing medication regimens. By stimulating salivation with an acidic citrus fruit ice cream, the need for fluids was reduced, while the caloric intake was increased.
S19	Non-pharmacological: saliva substitutes; artificial saliva, glycerin combined with lemon. Saliva stimulants, organic acid and chewing gum, pilocarpine, ascorbic acid, citric acid, mouthwash. Malic acid and acupuncture. Pharmacological: nicotinamide, pilocarpine, bethanechol choline esters, anticholinesterases, distigmine and pyridostigmine.	Doctors		Saliva stimulants are preferred over saliva substitutes. Chewing gum is effective and well tolerated and can be a good first-line treatment. Acupuncture has been recognized as a treatment for xerostomia in Chinese medicine. Recently adopted by western medicine. Dietary advice can be helpful for a person to control xerostomia.

I -The interventions used to control xerostomia in palliative patients

The interventions used for xerostomia control in palliative patients, the studies point out for the following non-pharmacological interventions: acupuncture (E1, E2, E3, E4, E5, E6, E9, E11, E12, E19), saliva substitutes as artificial saliva and glycerine (E2, E10, E11, E12, E15, E19), saliva stimulants as: chewing gum, ascorbic acid, citric acid and malic acid (E2, E3, E6, E7, E9, E10, E11, E13, E14, E15, E18, E19). Still under the non-pharmacological intervention scope are: the food regimen changes, avoiding alcohol beverages and sugar rich foods (E3, E6, E13, E16, E19), the importance of oral hygiene educational programmes (E6, E9, E12, E15) and electrostimulation (E6). The pharmacological interventions were also highlighted as an important treatment in xerostomia control like the parasympathomimetic medicine: pilocarpine (E2, E3, E6, E11, E16, E17, E19) and bethanechol chloride (E2, E6, E16, E19).

ii- Characteristics (intervention and duration type) of those interventions

In what concerns the intervention characteristics, the studies point out to the non-pharmacological interventions frequency that depends on the type of treatment used. Acupuncture was used for 5 weeks, two times per week (E4) in a total of 4 or 6 treatments (E5). The saliva stimulants were used for three to five days (E7, E10) and citric acid before meals were used for six weeks (E18). Saliva substitutes were used between 7 to 14 days (E14). Pharmacological interventions were based on the use of pilocarpine three times a day for a week (E17).

iii- Specific health professional area that performs those interventions

The xerostomia control interventions were used mainly by: dentists (E3, E7, E8, E12, E13, E14), nurses (E2, E9, E12, E18), nurses with acupuncture training (E4), doctors (E2, E19), acupuncturists (E5) and health professionals in oncology, palliative care and odontology (E6, E17). Diagnosis tests with yes or no questions were used to assess some of the interventions as the salivary function and the saliva substitutes effect. (E13). Clinical assessment of the client's oral cavity, upon admission to the health service and its reassessment at regular intervals, was the strategy used to understand the effectiveness of educational programmes on the relevance of oral hygiene. (E9). The use of acupuncture to control xerostomia was evaluated in one of the studies used in this review, through a visual analogue scale, and by measuring saliva production before and after treatment (E4).

3. DISCUSSION

The studies under review revealed that xerostomia is a common symptom in palliative and end-of-life patients. This symptom is usually associated with significant morbidity and a decrease in the quality of life of these patients. (Meidell & Hoiritz Rasmussen, 2009; Lopez et al., 2018; Sheehy, 2013, Reisfield et al., 2009). Fleming and collaborators (2020) While assessing the xerostomia impact in daily activities (from 135 patients with advanced and progressive disease) concluded that xerostomia had a major negative impact in speaking capability, eating and food tasting. This situation also interfered with nasal mucosa dryness, swallowing and sleep. Saliva produced by the parotid, submandibular and sublingual glands is estimated to be about 0.5 L/day to 1 L/day and flow rates can fluctuate up to 50% with diurnal rhythms in adults. Salivary dysfunction (translated by the decrease in these flows) can be induced by drug therapy; disease states, radiotherapy treatment; anxiety, depression or stress (Moore & Guggenheimer, 2008). Xerostomia is reported by end-of-life patients to be an uncomfortable and very distressing symptom. (Sheehy, 2013). As a consequence, pain in the oral cavity, accelerated dental morbidity, infections of the oral mucosa, fissures and ulcers, halitosis, alteration in the taste and appreciation of food, chewing and swallowing difficulties, nutritional impairment, difficulty in speaking perceptibly and related problems with the dental prosthesis can arise (Reisfield et al., 2009, Fleming et al., 2020). According to this review, it has become consensual that the etiology of xerostomia is multifactorial, and may be associated with the adverse effect of treatment with anticholinergic, antiadrenergic or cytotoxic drugs, which cannot be discontinued due to the refractory symptoms that people in palliative situations have. (Barford & D'Olimpio, 2008; Moore & Guggenheimer, 2008; Reisfield et al., 2009; Sheehy, 2013; Crogan, 2015). Xerostomia is associated to radiotherapy treatments (Nieuw Amerongen & Veerman, 2003; Kahn & Johnstone, 2005; Moore & Guggenheimer 2008; Reisfield et al., 2009; Mercadante et al., 2000), anxiety, depression and stress states (Moore & Guggenheimer 2008; Reisfield et al., 2009). The analysed studies allowed mapping interventions for the control of xerostomia in palliative care. The systematic evaluation of the oral cavity is presented as an intervention of great relevance (Sheehy, 2013; Lopez et al., 2018). The remaining interventions were grouped into three areas: preventive care, symptom relief and training of family caregivers. (Sheehy, 2013). In what concerns preventive care, it includes hydration, oral hygiene with a small brush for 2 minutes, odontology consultation and ambient humidification (Venkatasalu et al., 2020, Sheehy, 2013). Symptom relief involves the use of non-pharmacological measures as well as pharmacological measures, resorting to the treatment of the underlying cause and the use of polycarpine. (Mercadante et al., 2000). Under non pharmacological measures it is included saliva production stimulation resorting to the use of saliva stimulants instead of substitutes as well as diet adequacy (Davies et al., 2011; Crogan, 2015) and acupuncture (Meidell & Holritz Rasmussen, 2009; Lopez et al., 2018). The seven primary analysed studies allowed us to know that the evidence relating to the type of treatment for xerostomia needs a larger number of clinical trials with amplified samples. Acupuncture revealed to be efficient in the relief of oral cavity dryness (Meidell & Holritz Rasmussen, 2009; Lopez et al., 2018). The idea of the need to obtain more studies, with larger samples, about the use of acupuncture in the relief of xerostomia, in people in palliative and end-of-life situations, is unanimous. (Lopez et al., 2018). Randomized clinical trials support the use of pilocarpine and saliva stimulants, such as chewing gum and citric acid-rich stimulants, in the treatment of xerostomia (Davies, 2000; Mercadante et al., 2000; Crogan,2015; Kvalheim et al., 2019).

This revision allowed us to understand the importance of educating xerostomia patients and families about measures to take to prevent complications and get relief from symptoms (Sheehy, 2013). This revision is an opportunity to point out the oral care. Even though they are basic and essential care most of the time health professionals, by many reasons, end up omitting them, because they are considered as a non-priority care in relation to other care (Lourenço, 2017). Since this theme has interference with quality of life, especially for those with xerostomia, this scoping revision is of great value since it connects the aspects related to the need for systematic assessment of the oral cavity, preventive care, symptom relief and treatment of xerostomia. It guides as well quality clinical practices necessary for those in a palliative and end-of-life situation that suffers with or have tendency to develop this problem.

CONCLUSION

Xerostomia is a health condition that can cause halitosis, sleep disorders, speech deficits, chewing and swallowing disorders, which result in malnutrition. Consequently, it generates social embarrassment and chronic discomfort, causing suffering and a great impact on people's quality of life. Due to the prevalence of patients in palliative and end-of-life situations and the scarcity of an existing evidence base, more research is required to improve the quality of life, a reality for people who suffer from xerostomia. It is critical for health professionals to prioritize oral cavity assessment and preventive care interventions, focusing on hygiene care and oral hydration, and environmental humidification, without forgetting people with compromised conscience. The prevention and relief of symptoms, in people with the potential risk of developing xerostomia, associated with taking medication, treatments such as radiotherapy, and states of anxiety, depression, and stress, is also a priority. Grouping and synthesizing the available evidence, within this theme, can help health professionals to incorporate them into clinical practice, thus contributing to an increase in excellence in the provision of care. The limitations and weaknesses perceived, throughout and during this research, are related to the reduced scientific dissemination, updated on this topic, and the scarcity of studies focused on the systematic evaluation of the interventions implemented for the control of xerostomia.

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REDE CEGONHA NA VISÃO DE PROFISSIONAIS DE SAÚDE: DESAFIOS E ESTRATÉGIAS DE SUPERAÇÃO

THE STORK NETWORK IN THE VIEW OF HEALTH PROFESSIONALS: CHALLENGES AND THEIR OVERCOMING STRATEGIES

LA RED CIGÜEÑA EN LA VISIÓN DE LOS PROFESIONALES SANITARIOS: RETOS Y ESTRATEGIAS DE SUPERACIÓN

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RESUMO

Introdução: A Rede Cegonha (RC) visa articular as ações materno-infantil, buscando um atendimento humanizado e integral. Porém, há desafios a serem compreendidos no processo de implementação dessa política púplica no Brasil.
Objetivo: Analisar a percepção dos profissionais da Atenção Primária à Saúde sobre os desafios e suas estratégias de superação na implementação do cuidado na Rede de Atenção à Saúde e na Rede Cegonha.
Métodos: Grupos focais com duas equipes Saúde da Família (eSF) e duas de Unidade Básica de Saúde (UBS) que acompanham as gestantes, totalizando 35 participantes. Realizada análise de conteúdo, modalidade temática com os dados coletados.
Resultados: Percebe-se que o trabalho em rede não tem funcionado no município, tendo deficiência com relação ao estabelecimento dos fluxos, com pouca capacidade de resolução das situações frente aos processos de comunicação formal. As propostas de superação dos desafios passam pela reconstrução dos fluxos, protocolos e comunicação entre os serviços, mas também num movimento de cogestão.
Conclusão: Outras investigações são necessárias frente às novas políticas públicas implementadas no Brasil, o que gera desafios frente à proposta de integralidade no cuidado em saúde.

Palavras-chave: política pública; serviços de saúde materno-infantil; integração de sistemas; saúde da mulher

ABSTRACT

Introduction: The Stork Network (RC) aims to articulate maternal and child actions, seeking a humanized and comprehensive care. However, there are challenges to be understood in the process of implementing this public policy in Brazil.
Objective: To analyze the perception of Primary Health Care professionals about the challenges and their overcoming strategies in the implementation of care in the Health Care Network (RAS) and in the Stork Network.
Methods: Focus groups were performed with two Family Health Teams (FHTs) and two Basic Health Units (BHUs) that follow pregnant women, totaling 35 participants. The content analysis of the collected data was performed, using the thematic modality.
Results: It was observed that networking has not shown a good performance in the municipality, showing a deficiency in relation to the establishment of flows, with little capacity to resolve situations in the face of formal communication processes. The proposals for overcoming the challenges go through the reconstruction of flows, protocols and communication between services, but also include a co-management movement.
Conclusion: Further studies are necessary considering the new public policies implemented in Brazil, which creates challenges in the face of the proposed integrality in health care.

Keywords: public policy; maternal and child health services; systems integration; women's health

RESUMEN

Introducción: La Red Cigüeña pretende articular las acciones materno-infantiles, buscando una atención humanizada e integral.
Objetivo: analizar la percepción de los profesionales de la Atención Primaria a la Salud sobre los retos, así como elaborar estrategias de superación para actuar en la Red Cigüeña.
Métodos: Grupos focales con 34 profesionales de las Estrategias de Salud de la Familia (ESF) y Unidades Básicas de Salud (UBS) que monitorizan a las embarazadas. El análisis realizado fue por medio del análisis de contenido, modalidad temática.
Resultados: Se han tratado dos temas en este artículo: Retos y propuestas para la actuación de los profesionales de la ESF en la Red de Atención a la Salud y la Red Cigüeña; y, Retos y propuestas para la actuación de los profesionales de las UBS en la Red de Atención a la Salud y la Red Cigüeña.
Conclusión: Se identificó la fragilidad en el trabajo en red, como el establecimiento de los flujos, la baja capacidad de resolución de las situaciones frente a los procesos de comunicación formal y la rotación de los profesionales de la salud. Las propuestas de superación de los retos pasan por la reconstrucción de los flujos entre los servicios y la implantación de la Red Cigüeña en el movimiento de cogestión.

Palabras Clave: políticas públicas; servicios de salud materno-infantil; integración de sistemas; salud de la mujer

INTRODUCTION

One of the great challenges related to women's and children's health care is to guarantee high-quality prenatal care. This goal is tangible when pregnant women exercise their rights through the existence of spaces aimed at the sharing of experiences and questions, preparing them for the moment of delivery (Brasil, 2007).

Comprehensive prenatal care ensures conditions for a healthy pregnancy and birth, considering biopsychosocial aspects, through health education and prevention activities. The comprehensiveness of prenatal actions and services must be articulated from a network perspective, consistent with the doctrinal principles of the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), at all levels of care (Costa et al., 2016).

Currently, a standardized work pattern still persists, which limits the work of the professionals, preventing more creative actions with closer relationships and with a greater degree of freedom. Hence, networking seeks to acknowledge the uniqueness of the individuals, allowing embracement, the building of bonds, accountability, as guidelines of the health model, in addition to providing multiple connections, favoring the effectiveness of care (Franco, 2013).

To overcome the challenges of disarticulation, the Ministry of Health (MH) proposes that services can be organized into care networks. The ordinance that established the guidelines for the organization of Health Care Networks (RAS, *Redes de Atenção à Saúde*) was published in 2010 (Brasil, 2010).

The production of care in networks directed by the RAS guidelines and built through horizontal relationships, considers Primary Health Care (PHC) as the organizer of the entire system, the link between the individual and the levels of technological complexity. PHC is the gateway to the system and must meet the health needs of the population in the territory under its responsibility. In this context, the professionals of the teams are responsible for the production of health care and for sharing the objectives and expected results (Cecílio et al. 2012; Santos, 2017).

Considering a scenario of fragmented and disarticulated care production between the health services for the mother-child binomial, the proposal to implement the Stork Network (RC, *Rede Cegonha*), created in 2011 by the Ministry of Health (MH) appeared, focused on the integrality of the care. The RC was structured into four components: prenatal care, childbirth and birth, puerperium and comprehensive care to children's health and a logistical system related to sanitary transportation and regulation (Brasil, 2011).

At the regional level, a document was prepared in 2012 proposing the implementation of the RC and the Action Plan contemplating the MH guidelines, with a new organizational model that would allow establishing coping strategies and implementations in the maternal-child area (Costa et al., 2016).

Therefore, the RC aims to articulate maternal-child actions, seeking humanized and comprehensive care, promoting the connection between the flows, the integration of health actions and services to enable an efficient and high-quality assistance at all points of care, focused on user satisfaction and the improvement of maternal and child morbidity and mortality indicators (Assis et al., 2019).

In this sense, the RC faces the challenge of establishing a change in the health care model and, particularly, in the field of management, requiring new forms of qualification and organization of work and the institutional and subjective relationships. Thus, it is possible to build a transformative potential for the sustainability of the RC practices as a public policy and the production of the collectives' autonomy in health, strengthening its results and the innovations in care networks (Santos & Ventura, 2021).

Therefore, it is necessary to explore how health teams are carrying out their practices in health services, considering that we live with the care models of the Family Health Strategy (FHS) and Basic Health Units (BHUs) in PHC, in Brazil.

Hence, in this context, the following question is asked: What is the PHC health teams' perception in relation to Health Care Network (RAS, *Rede de Atenção à Saúde*) and the RC, considering the gestational period? How do these teams operationalize the actions recommended by the networks?

The objective is, therefore, to analyze the perception of Primary Health Care professionals about the challenges and their overcoming strategies in the implementation of care in the Health Care Network and in the Stork Network.

1. METHODS

A qualitative, exploratory-descriptive study was carried out in the Health Units that comprise the PHC Network in a medium-sized municipality in the interior of the state of São Paulo, Brazil.

1.1 Sample and inclusion and exclusion criteria

In this context, 38 Family Health Teams (FHTs) and 12 Basic Health Units (BHUs) were organized.

To carry out the investigation, the inclusion criteria comprised a FHT and a BHU team, from the assessed municipality, with the highest number of registered pregnant women and the highest number of referrals to the high-complexity hospital and a FHT and a BHU team with lowest number of registered pregnant women and highest number of referrals to a high-complexity hospital.

The sample was obtained by convenience, in which the BHU scenario included professionals who provided care to pregnant women and, for the FHT, the proportional representativeness of the professional categories that comprised the team was defined.

The focus groups were carried out in different places, with two teams at the BHU and two at the FHT. In the *Diamante* and *Safira* FHTs, the groups consisted of: three physical therapists, two physicians, two nurses, two nursing assistants, two oral health assistants, a writing assistant, five community health agents (CHAs), a nutritionist, two endemic disease control agents (ECAs), two cleaning assistants and an undergraduate sixth-year medical student from *Faculdade de Medicina de Marília* (FAMEMA).

In the *Esmeralda* and *Rubi* BHU teams, the groups consisted of: two nurses, two obstetricians, three nursing technicians, four community health agents and an endemic disease control agent.

1.2 Data collection instrument

Data collection was carried out from July to October 2019. The focus group (FG) technique was used, which aims at collecting data through the interaction between the participants to explore the guiding topics (Nyumba et al., 2018). A script was used that included guiding questions about the challenges and the overcoming strategies in the implementation of the RAS and RC in the PHC of the assessed municipality. A meeting was held for each group, with an average duration of 60 minutes. The group was led by the main researcher and was supported by two others who had experience on the topic and the collection method.

1.3 Data analysis

The content analysis technique was used to analyze the focus groups' data, using the thematic modality, where the central concept is the topic (Minayo, 2013). In the pre-analysis, the content of the focus groups was organized for a floating and exhaustive reading. During this process, the categories of analysis related to the challenges and overcoming strategies for the implementation of the RAS and RC were defined. The material from the FHT and the BHU was processed separately, with a separate Excel spreadsheet, so that the categories were explored considering the professionals' perception in each care model (FHT and BHU).

The second phase comprised the exploration of the collected material, selecting the speech fragments according to the established categories. Then, the synthesis of each category was carried out, which allowed identifying the core of meaning and group them into topics (Table 1). The coding of data was performed by a researcher and validated by two others with a PhD and experience in the analysis method.

The third phase consisted in the presentation, discussion and interpretation of the collected data. In this phase, the authors worked with the references of integrality in care and co-management in health.

Aiming to preserve anonymity, the Health Units were identified by aliases: FHT *Diamante*, FHT *Safira*, BHU *Rubi* and BHU *Esmeralda*.

Chart 1 – Presentation of the topics and cores of meaning of the interviews with the professionals from the FHTs and BHUs, Marília, São Paulo, Brazil, 2020.

Topics	Cores of meaning
Challenges and proposals for the performance of FHT professionals in the Health Care Network and Stork Network	- Difficulties in the transition from the biomedical model to the FHS; - Disarticulation between the different services of the Health Care Network and Stork Network; - Need to increase the number of professionals and acknowledgement of their work; - Need for clarity in the definition of roles and protocols; - Importance of health education actions;
Challenges and proposals for the performance of BHU professionals in the Health Care Network and Stork Network	- Organization of the work process makes it difficult to carry out health promotion and prevention actions; - Divergence of guidelines and flows among the professionals of the PC team; - Disarticulation between the different services of the Health Care Network and Stork Network; - Lack of knowledge about the public policies on the part of the professionals and pregnant women; - Insufficient structural and organizational resources; - Importance of health education actions and the reduced number of professionals; - Need to qualify professionals for humanized care; - Need to increase the number and variety of professionals; - Intensify preventive actions to impact on health indicators;

Source: Research data

This article is part of a professional Master's Degree dissertation, approved by the Research Ethics Committee (REC) and by the Research Evaluation Committee of the Health Secretariat (COMAP), under CAAE registration: 02874218600005413 and Opinion N. 3,123,730.

3. RESULTS

The topics and cores of meaning identified from the speeches of the FHTs and BHU professionals will be shown below.

3.1 Challenges and proposals for the performance of FHS professionals in the Health Care Network and the Stork Network (*Rede Cegonha*)

One of the challenges faced by the FHTs is the change from the curative model to that of disease prevention and health promotion, as service users demand urgent care and believe in the power of medication to solve their problems. The professionals report that this occurs due to people's difficulty in understanding. Moreover, the validity of the two Health Care models in the municipality also makes the implementation of the FHS difficult, weakening the CN and RC (Oliveira et.al., 2021)

> “*The people, they are very demanding [...] they are looking for a more curative model, they want medication and that is it [...]. It is the lack of understanding, it is the urgent care. And, as there are two models of assistance [in the municipality], the BHU is different from the Strategy. [...] it makes it a little difficult, due to the very comprehension”.* (FHT, team *Diamante*).
>
> The respondents point out that the perspective is to develop a practice with quality, but this goal is not achieved due to lack of time caused by the high demand, as there has been an increase in SUS-dependent users. And, moreover, due to the insufficient number of health workers in the FHTs.
>
> *“[...] we end up not having enough time to work with the quality we wanted, because the demand is very high, the population is much more “SUS-dependent” [...], we currently do not have a sufficient number of professionals”.* (FHT, Team *Diamante*)

The Family Health Support Center (NASF, *Núcleo de Apoio à Saúde da Família*) teams do not have an established frequency in the units, which makes them lose the characteristics of the FHS. Nevertheless, the Secondary Hospital contacts the PHC services in order to develop the RAS. In relation to the NASF, it created orientation and/or operational groups in partnership with different professionals from the FHTs, as this activity was considered essential to operationalize the principles of the FHS. However, this action is currently not considered essential.

> “*At NASF we do not have a frequency at the Units and the strategy is lost, a little bit of the characteristics of the Strategy [...] the Strategy is no longer able to play its role. The Secondary Hospital continues to work within a possible flow [...], when one talks about Strategy, one thinks [...] we talk about the group, it is no longer like that, it was not like that anymore, but it was a little more. Today the demand is greater and so is professional turnover*. (FHT, Team *Diamante*)

In this context, the FHT professionals indicate that they live with a model that is values the quantitative production of "procedures" and not the integral care of the pregnant woman, being influenced and determined by the reduced number of professionals in the team and in NASF, in addition to the turnover of these professionals, thus not allowing the possibility of creating a bond between professionals for the success of the teamwork, seeking the intention of reconstructing practices.

The professionals who comprise the FHTs recognize the importance of guidance and/or operative groups for pregnant women, despite the low adherence when they are carried out. In the set of statements, they state that it is necessary to use appeals or to have the participation of the physician to increase the number of pregnant women.

> “*The group is very important [...] it is the population that has a low adherence, there has to be something very appealing for them to attend the groups [...] the groups that are most frequently attended are the ones that we say the doctor will be present or when they will get something*”. (FHT, Team *Diamante*)

Professionals report that with the implementation of the e-SUS (Electronic Health System), there was an improvement in user information, allowing access to service networks and records of the production of each PHC professional for some specialties. However, there is no established effective flow of referral and counter-referral and annotation in the pregnant woman's pregnancy card about the care provided. They understand that interdisciplinarity is important for the comprehensive care of pregnant women in all areas of Health Care. The exception is the secondary referral hospital, as mentioned above. They indicate the need to create an intermediate-risk outpatient clinic to overcome the difficulty of communicating with the high-risk one, as well as improve the operation of the latter.

> “*With the E-SUS, it has improved for some specialties, but it doesn't work in hospitals [...] the communication [...] on both sides. To facilitate this channel, because it is very difficult to integrate the network, mainly because the system is not the same, so there is no way to have other information, unless someone gives it to us. It is different in the hospital [...], I can see it because it is the same system. Communication is important.”* (FHT, Team Safira)
>
> “*In all areas of care, I believe that interdisciplinarity at the time of evaluating and addressing the health needs will be important”.* (FHT, Team *Safira*)
>
> “*There is no counter-referral. Everyone wants us to refer to them, the counter-referral to know what was done with the patient, never”.* (FHT, Team *Diamante*)
>
> *“We lack a medium-risk and intermediate-risk outpatient clinic, and we lack a better high-risk outpatient clinic, because the high-risk outpatient clinic in Marília is very complicated [...] with the intermediate-risk outpatient*

> *clinic, a good part of these difficulties that we have with the high-risk would be resolved".* (FHT, Team *Safira*)

There were also weaknesses regarding the communication between the members of the FHT itself and between the FHT and the Municipal Health Secretariat (SMS, *Secretaria Municipal de Saúde*) to discuss cases, making it difficult to establish a bond. They point to the lack of implementation of protocols for the care of pregnant women in the municipality and the addition of new tests with the definition of parameters for referrals to different health services, aiming to facilitate the creation of effective flows in care promotion.

> *"They are very seriously overloaded there, because they (SMS) also have to attend to the entire municipality, and it is not just those things related to pregnant women, there are several other things [...] they (SMS) are also in meetings all the time, they are talking to someone, that bond is missing".* (FHT, Team *Safira*)

> *"This part of calling them and discussing (with the Technical Area of Women's Health in the SMS) is complicated [...], because when we have (doubts) we call, then there is no one there or, if there is someone, they are busy: could you call later? [...] it is very difficult for us, because as we don't know where to send this pregnant woman, because we don't have the level of complexity that she needs, we have to keep calling and discussing the case all the time".* (FHT, team *Safira*)

> *"There is no protocol in the municipality [...], protocol B is something that is already collected [...] here, in the municipality, there is no such thing [...] there are diabetics who become pregnant and pregnant women who become diabetics, and there is the risk level of this patient [...]. There is a patient who has an indication for insulin use and there is a patient who is diabetic, but it is not severe, where do we send her to?".* (FHT, Team Safira)

Moreover, they imply that humanized childbirth is not present, and it is necessary to train professionals to do so.

> *"I think there is a lack of preparation for the humanization of childbirth, we hear a lot about humanized childbirth [...] but there is no such thing".* (FHT, team *Safira*)

3.2 Challenges and proposals for the UBS professionals' performance in the Health Care Network and Stork Network

Health workers say that PHC has, among its attributions, prevention through groups, such as pregnant and postpartum women, but due to the "acute complaint" of the population, which demands rapid resolution, and the reduced number of professionals, their development is no longer a priority for the team.

> *"Primary Care predicts dealing a lot with prevention and we end up not having the resources to actually make prevention happen, through groups [...] here we have many pregnant women and this work could be done [...] but we lack professionals [...] we have a situation of acute complaints that needs quick resolution, the groups always end up being overlooked, information ends up being overlooked*". (BHU, team *Esmeralda*)

The professionals who comprise the UBS teams report that one of the challenges is communication and the flow of PHC with Secondary Care. They consider that if the user is referred from PHC to the hospital, they are forwarded to the PHC Emergency Room (ER). However, the secondary service has as its purpose the qualified hospital discharge, but they also have operationalization difficulties. Therefore, the PHC services hardly receive this counter-referral.

> "*I was taught that if I need to seek out the HM, which is the referral for pregnant women, that won't happen. Because the person goes there and they send her back to the ER. So, I think this is not well established, screened*." (BHU, Team *Rubi*)

> "*The Secondary Hospital works a lot with qualified hospital discharge, they try to work with this tool, but they don't have conditions to do that to all patients. So that happens very rarely."* (BHU, Team *Esmeralda*)

There is a lack of information on the part of professionals and pregnant women about public policies and there is no training for workers regarding this issue.

> "*The lack of information, both on the part of the population and the professionals, about the public policy, is not worked out, trained, I have never seen anyone train a team in public policies".* (BHU, Team *Esmeralda*)

They also indicate the lack of structural and organizational resources such as: offering exams, administrative incompetence and the lack of availability of managers to transform the current scenario.

> "*In the municipality [...] two thousand late ultrasounds, X-rays, surveys from all units [...] if there is an indication for resonance [...]".* (BHU, Team *Esmeralda*)

> "*The managers are incompetent [...] it is not the financial type, but there is administrative incompetence [...]. We are abandoned".* (BHU, Team *Esmeralda*)

In the set of statements, there is a suggestion to increase the number of professionals, in all categories.

> *"This is the suggestion: more physicians, more professionals, social workers, nutritionists, I think that would solve one of the problems, but we don't have enough professionals in the network"*. (BHU, team *Rubi*)

The professionals point out that the health unit is not playing its role of promoting preventive actions, such as, for instance, they do not carry out home visits. Furthermore, they do not generate indicators that allow them to acquire knowledge on these people to develop these activities. They believe that these are PHC attributions and that they do not fulfill them due to lack of resources.

> *"The preventive exam would be more the responsibility of the Family Health Unit (FHU), the home visit that you have to do, where you have to go, get the vaccine, the preventive would be the responsibility of FHU [...] it is also stopped, it is not fulfilling its purpose. The only thing missing are the indicators, we cannot generate indicators due to this lack of resources [...] we need to generate indicators to recognize that population: I need to work on prevention, syphilis [...] with this lack of resources, we cannot really fulfill the role of Primary Care".* (BHU, Team *Esmeralda*)

4. DISCUSSION

One of the central challenges experienced by PHC teams are the changes in the health care model. We live with the biomedical model and the health surveillance model, producing different understandings about how to implement the actions proposed in the RC.

In the assessed municipality, it was observed that pregnant women have access to start their care both with the FHT and in the BHU. However, the provision of care still shows difficulties for its occurrence in a team, including the NASF, with one of the determinants being the reduced number of professionals to develop the proposed actions.

The challenge of building, together with the pregnant women, a practice focused on health promotion and disease prevention has also been perceived. This indicates that pregnant women require practices anchored in the biomedical model; however, this transition of the care model is a process that occurs between professionals, managers, as well as the pregnant women.

The pregnant women's conception of health care is based on the biomedical model, evidenced by the greater appreciation of medical consultations and the procedures of hard technology that are performed, centralizing their health production in the medical act and may disregard collective actions or those by other professionals in the construction of assistance in prenatal care. Fogaça et al. (2017) state that the pregnant women's attitude could be different if there was an understanding of their role as a co-participant in the production of their care during the creation of the care plan in prenatal consultations.

It is understood that the biomedical model was socio-culturally established with people over decades, and its deconstruction requires agreed actions between managers, professionals and the community, in addition to involving professional training, in a co-management movement. The focus lies on the analysis of the work as a concrete activity, understanding how collectives operate daily, what the teachings are between the segments, how they articulate and reinvent themselves (Santos & Ventura, 2021).

With the increase in the number of users who depend on access to the SUS, much more work is done regarding the number of scheduled appointments and the needs of pregnant women, adults, children, adolescents, hypertensive patients, diabetics, the elderly, unable to make home visits. In this context, the FHT professionals indicate that they live with a model that is valuing the quantitative production of "procedures" and not the integral care of pregnant women, being influenced and determined not only by the reduced number of professionals in the team and the Family Health Support Center (NASF) but also the turnover of these professionals, thus not allowing the possibility of building a bond between the professionals themselves for the effectiveness of teamwork, aiming at practice reconstruction.

The availability of a sufficient number of professionals humanizes and qualifies the provision of care. Qualified listening strengthens the bond with pregnant women assisted in prenatal care (Silva et al., 2018). That is, even if there is an effort on the part of the teams to make changes in the organization of care for pregnant women, there is a public policy proposition to structure practices aimed at a quantitative production to the detriment of the search for quality anchored in the integrality of care.

A regression of the FHS care model and the multidisciplinary teams in PHC policies can be observed, with the reduction in the number of professionals working in health units. New organizational models were allowed from the 2017 National Primary Care Program (PNAB, *Programa Nacional de Atenção Básica*) in Brazil, with the reduction and even the absence of the NASF and Community Health Agents (CHAs) in the teams and that influences the conception of the social determination of the health-disease process and the extended clinic. The physicians will be able to reduce their workload and their work tends to be focused on curative and individualized actions (Giovanella, Franco & Almeida, 2020).

The extinction of the accreditation and federal funding of NASF highlights another point of involution. The concept of multiprofessionality and interdisciplinarity tend to disappear, as the priority will be individual care and the meeting of spontaneous demand. According to Giovanella et al. (2020), there is a tendency for the FHS to be mischaracterized in its work process, from the capillarity of the teams in the communities and the organization of actions. It may compromise the longitudinality and coordination of care, disarticulated from the emergency networks and directed at acute demands and disease management, with the monitoring of severe cases awaiting transfer. To considering only the registered population, in practice, means breaking up with the universality and equity of the SUS.

The professionals who constitute the PHC teams report that another challenge is network care, based on integrality as a guiding principle, that is, the communication of the PHC with Secondary Care and Hospital Care, between the members of the FHT itself and between the latter and the SMS to discuss cases, in addition to the difficulties regarding counter-referral by hospital care.

These teams, which are responsible for the production of care, point out the lack of implementation of protocols for pregnant women in the municipality and the addition of new tests with the definition of parameters for referrals and places for delivery, and identification of effective flows of care in the municipality.

The professionals understand that interdisciplinarity is important for the comprehensive care of pregnant women and in all areas of Health Care. They state that the secondary referral hospital works within a possible flow with the discussion of some cases creating networks within the PHC health units.

With the implementation of the electronic system for recording data in the SUS (e-SUS), there has been an improvement regarding user information, allowing access to service networks and records of the production of each PHC professional for some specialties. However, as there is no established effective flow of referral and counter-referral and annotation in the pregnant woman's card about the care provided, the networking remains compromised. For that purpose, it is suggested that professionals be trained on the public policies of the RAS and RC, so that they, together with the managers, can establish the reorganization of care.

The organization of RAS and RC is essential for humanized care, being focused on comprehensive care, ensuring access, embracement and effectiveness (Silva et al., 2018). Pregnant women being monitored in health units experience different scenarios, which require different perspectives.

The professionals list as proposals to overcome the challenges the need to improve the definition of roles and protocols of health services, aiming at integration of care and creating the intermediate risk or medium complexity outpatient clinic to discuss cases that generate doubts for professionals.

One proposal would be to redesign the Health Regions, defining them as responsible for the management of medium and high-complexity cases and of Health Surveillance, including Hospital Care that has been operationalized, disconnected from PHC and operating with efficiency and effectiveness problems.

Aiming to contemplate the presented proposals and SUS sustainability, it is necessary to train professionals and multiprofessional teams, which will address the health needs of the territories and their contexts, with the management focused on this context. Interdisciplinary practice should be encouraged, as well as the sharing of responsibilities and tasks. Campos (2018) highlights that the fragmented care process between services, and the movement of users as sliding pieces, has inhuman, ineffective and inefficient results. It is essential that there be an improvement in communication and integration of services for the democratization and sustainability of SUS, and the FHS expansion is a strategy to be considered.

CONCLUSION

It is observed that networking has not been effective in the municipality, showing deficiencies in relation to the establishment of flows, with little capacity to resolve situations in the face of formal communication processes, either through a referral and counter-referral system, or even between the team professionals, whose number have been reduced and also considering professional turnover both in the referral team and in the NASF.

The proposals for overcoming the challenges go through the reconstruction of flows, protocols and communication between services, but also with the municipal management of women's health area, aiming to provide the collective construction of the implementation of the RC in a co-management movement.

A new look at the dynamics of centralization and decentralization of actions established on National Health Policies, built and approved by the SUS co-management bodies: Conferences, Councils and Tripartite Commissions is essential. There is a recent tendency to dismantle these policies, further fragmenting SUS and exposing state and municipal administrations to the pressure from external groups' interests to take advantage of SUS.

The study limitation related to the portraying of Networking in a single municipality is recognized; therefore, further investigations are necessary considering the new public policies implemented in Brazil, which creates challenges in the face of the proposal of integrality in health care.

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REDE CEGONHA NA VISÃO DE PROFISSIONAIS DE SAÚDE: DESAFIOS E ESTRATÉGIAS DE SUPERAÇÃO
THE STORK NETWORK IN THE VIEW OF HEALTH PROFESSIONALS: CHALLENGES AND THEIR OVERCOMING STRATEGIES
LA RED CIGÜEÑA EN LA VISIÓN DE LOS PROFESIONALES SANITARIOS: RETOS Y ESTRATEGIAS DE SUPERACIÓN

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RESUMO

Introdução: A Rede Cegonha (RC) visa articular as ações materno-infantil, buscando um atendimento humanizado e integral. Porém, há desafios a serem compreendidos no processo de implementação dessa política púplica no Brasil.
Objetivo: Analisar a percepção dos profissionais da Atenção Primária à Saúde sobre os desafios e suas estratégias de superação na implementação do cuidado na Rede de Atenção à Saúde e na Rede Cegonha.
Métodos: Grupos focais com duas equipes Saúde da Família (eSF) e duas de Unidade Básica de Saúde (UBS) que acompanham as gestantes, totalizando 35 participantes. Realizada análise de conteúdo, modalidade temática com os dados coletados.
Resultados: Percebe-se que o trabalho em rede não tem funcionado no município, tendo deficiência com relação ao estabelecimento dos fluxos, com pouca capacidade de resolução das situações frente aos processos de comunicação formal. As propostas de superação dos desafios passam pela reconstrução dos fluxos, protocolos e comunicação entre os serviços, mas também num movimento de cogestão.
Conclusão: Outras investigações são necessárias frente às novas políticas públicas implementadas no Brasil, o que gera desafios frente à proposta de integralidade no cuidado em saúde.

Palavras-chave: política pública; serviços de saúde materno-infantil; integração de sistemas; saúde da mulher

ABSTRACT

Introduction: The Stork Network (RC) aims to articulate maternal and child actions, seeking a humanized and comprehensive care. However, there are challenges to be understood in the process of implementing this public policy in Brazil.
Objective: To analyze the perception of Primary Health Care professionals about the challenges and their overcoming strategies in the implementation of care in the Health Care Network (RAS) and in the Stork Network.
Methods: Focus groups were performed with two Family Health Teams (FHTs) and two Basic Health Units (BHUs) that follow pregnant women, totaling 35 participants. The content analysis of the collected data was performed, using the thematic modality.
Results: It was observed that networking has not shown a good performance in the municipality, showing a deficiency in relation to the establishment of flows, with little capacity to resolve situations in the face of formal communication processes. The proposals for overcoming the challenges go through the reconstruction of flows, protocols and communication between services, but also include a co-management movement.
Conclusion: Further studies are necessary considering the new public policies implemented in Brazil, which creates challenges in the face of the proposed integrality in health care.

Keywords: public policy; maternal and child health services; systems integration; women's health

RESUMEN

Introducción: La Red Cigüeña pretende articular las acciones materno-infantiles, buscando una atención humanizada e integral.
Objetivo: analizar la percepción de los profesionales de la Atención Primaria a la Salud sobre los retos, así como elaborar estrategias de superación para actuar en la Red Cigüeña.
Métodos: Grupos focales con 34 profesionales de las Estrategias de Salud de la Familia (ESF) y Unidades Básicas de Salud (UBS) que monitorizan a las embarazadas. El análisis realizado fue por medio del análisis de contenido, modalidad temática.
Resultados: Se han tratado dos temas en este artículo: Retos y propuestas para la actuación de los profesionales de la ESF en la Red de Atención a la Salud y la Red Cigüeña; y, Retos y propuestas para la actuación de los profesionales de las UBS en la Red de Atención a la Salud y la Red Cigüeña.
Conclusión: Se identificó la fragilidad en el trabajo en red, como el establecimiento de los flujos, la baja capacidad de resolución de las situaciones frente a los procesos de comunicación formal y la rotación de los profesionales de la salud. Las propuestas de superación de los retos pasan por la reconstrucción de los flujos entre los servicios y la implantación de la Red Cigüeña en el movimiento de cogestión.

Palabras Clave: políticas públicas; servicios de salud materno-infantil; integración de sistemas; salud de la mujer

INTRODUÇÃO

Um dos grandes desafios relacionados à atenção à saúde da mulher e da criança é a garantia de um pré-natal de qualidade. Essa meta é tangível quando as gestantes exercem seus direitos por meio de espaços de compartilhamento de experiências e questionamentos, preparando-a para o momento do parto (Brasil, 2007).

A assistência integral no pré-natal assegura condições para uma gestação e nascimento saudáveis, contemplando os aspectos biopsicossociais, por meio de atividades de educação em saúde e prevenção. A integralidade das ações e dos serviços do pré-natal deve estar articulada na perspectiva de rede, em consonância com os princípios doutrinários do Sistema Único de Saúde (SUS), em todos os níveis de complexidade (Costa et al., 2016).

Atualmente, ainda, tem-se um trabalho normatizado, o que limita o trabalho dos profissionais, impossibilitando ações mais criativas, com relações mais próximas e com maior grau de liberdade. Nessa direção, o trabalho em rede busca respeitar a singularidade das pessoas, possibilitando o acolhimento, construção de vínculos, responsabilização, enquanto diretrizes do modelo de saúde, além de oportunizar múltiplas conexões, favorecendo a efetivação do cuidado (Franco, 2013).

Para superação dos desafios das desarticulações, o Ministério da Saúde (MS) propõe que os serviços possam se organizar em redes de cuidados. Em 2010, foi publicada a portaria que estabeleceu as diretrizes para a organização das Redes de Atenção à Saúde (RAS) (Brasil, 2010).

A produção do cuidado em redes ordenado pelas diretrizes das RAS e construídas por meio de relações horizontais, considera a Atenção Primária à Saúde (APS) a ordenadora de todo o sistema, o elo entre a pessoa e os níveis de complexidade tecnológica. A APS é a porta de entrada do sistema e deve atender às necessidades em saúde da população do território sob sua responsabilidade. Neste contexto, os profissionais das equipes são responsáveis pela produção do cuidado em saúde e em compartilhar os objetivos e resultados esperados (Cecílio et al. 2012; Santos, 2017).

Diante de um cenário de produção de cuidado fragmentado e desarticulados entre os serviços de saúde ao binômio mãe e criança, surge a proposta de implantação da Rede Cegonha (RC), criada em 2011, pelo Ministério da Saúde (MS) com foco na integralidade do cuidado. Esta foi estruturada em quatro componentes: pré-natal, parto e nascimento, puerpério e atenção integral à saúde da criança e sistema logístico que se refere ao transporte sanitário e regulação (Brasil, 2011).

Em 2012, a nível regional, elaborou-se documento com a proposta para a implantação da RC e o Plano de Ação contemplando as diretrizes do MS, com novo modelo organizacional que possibilitasse enfrentamentos e implementações na área materno infantil (Costa et al., 2016).

Assim, a RC visa articular as ações materno-infantil, buscando um atendimento humanizado e integral, promovendo a conexão entre os fluxos, a integração das ações e serviços de saúde para possibilitar uma atenção eficiente e de qualidade em todos os pontos de atenção, com foco na satisfação dos usuários, e a melhoria dos indicadores de morbimortalidade materno infantil (Assis et al., 2019).

Nesse sentido, a RC tem o desafio de constituir a mudança do modelo de atenção à saúde e, em especial, no campo da gestão, sendo necessário novas formas de qualificação e organização do trabalho e das relações institucionais e subjetivas. Dessa forma, pode-se construir um potencial transformador para a sustentabilidade das práticas da RC enquanto política pública e da produção da autonomia dos coletivos em saúde, fortalecendo os resultados da mesma e das inovações em redes de cuidado (Santos & Ventura, 2021).

Nesse sentido, faz-se necessário explorar como as equipes de saúde estão realizando suas práticas nos serviços de saúde, considerando que convivemos com os modelos de cuidado da Estratégia Saúde da Família (ESF) e Unidades Básicas de Saúde (UBS) na APS, no Brasil.

Assim, diante deste contexto questiona-se: Qual é a percepção das equipes de saúde da APS em relação à RAS e RC, considerando o período gestacional? Como essas equipes operacionalizam as ações preconizadas pelas redes?

Objetiva-se, portanto, analisar a percepção dos profissionais da Atenção Primária à Saúde sobre os desafios e suas estratégias de superação na implementação do cuidado na Rede de Atenção à Saúde e na Rede Cegonha.

1. MÉTODO

Estudo de natureza qualitativa, exploratório-descritiva, realizada nas Unidades de Saúde que compõe a Rede de APS em um município de médio porte no interior do Estado de São Paulo, Brasil.

1.1 Amostra e critérios de inclusão e exclusão

Nesse contexto havia a organização de 38 equipes de Saúde da Família (eSF) e 12 Unidades Básicas de Saúde (UBS).

Para a realização da pesquisa, considerou-se como critério de inclusão, uma eSF e uma equipe de UBS do município pesquisado com maior número de gestantes cadastradas e maior número de encaminhamentos ao hospital de alta complexidade e uma eSF e uma equipe de UBS com menor número de gestantes cadastradas e maior número de encaminhamentos ao hospital de alta complexidade.

Utilizou-se amostra por conveniência, em cujo cenário da UBS foram incluídos os profissionais que realizavam atendimentos com as gestantes e na eSF definiu-se a representatividade proporcional das categorias profissionais que compõem a equipe.

Os grupos focais foram realizados em locais distintos, sendo duas equipes na UBS e duas na eSF. Nas eSF Diamante e Safira os grupos eram compostos por: três fisioterapeutas, dois médicos, dois enfermeiros, dois auxiliares de enfermagem, dois auxiliares de saúde bucal, um auxiliar de escrita, cinco agentes comunitários de saúde (ACS), um nutricionista, dois agentes de controle de endemias (AE), dois auxiliares de limpeza e um estudante do curso de Medicina do sexto ano da Faculdade de Medicina de Marília (FAMEMA).

Nas equipes das UBS Esmeralda e Rubi os grupos eram compostos por: dois enfermeiros, dois médicos obstetras, três técnicos de enfermagem, quatro agentes comunitários de saúde e um agente de endemias.

1.2 Instrumento de recolha de dados

A coleta de dados foi realizada no período de julho a outubro de 2019. Utilizou-se a técnica de grupo focal (GF), o qual atende a finalidade de coletar os dados por meio da interação entre os participantes para explorar os tópicos norteadores (Nyumba et al., 2018). Utilizou-se um roteiro que contemplava questões norteadoras sobre os desafios e estratégias de superação na implementação da RAS e RC na APS do município investigado. Para cada grupo foi realizado um encontro, com uma média de 60 minutos de duração. O grupo foi conduzido pela pesquisadora responsável e apoiado por duas outras com experiência sobre a temática e o método de coleta.

1.3 Análise de dados

Para a análise dos dados dos grupos focais utilizou-se a técnica de análise de conteúdo, modalidade temática, onde o conceito central é o tema (Minayo, 2013). Na pré-análise organizou-se o conteúdo dos grupos focais para a leitura flutuante e exaustiva. Nesse processo definiu-se as categorias de análise referente aos desafios e estratégia de sua superação da implementação da RAS e RC. O material da eSF e da UBS foi processado separadamente, com planilha de excel distintas, de forma que as categorias foram exploradas considerando a percepção dos profissionais em cada modelo de cuidado (ESF e UBS).

A segunda fase constituiu-se da exploração dos materiais coletados, selecionando os fragmentos das falas de acordo com as categorias estabelecidas. Em seguida, elaborou-se síntese de cada categoria, a qual permitiu identificar os núcleos de sentido e agrupá-los em temas (quadro 1). A codificação dos dados foi realizada por uma pesquisadora e validada por duas outras com título de doutor e experiência no método de análise.

Na terceira fase realizou-se a apresentação, discussão e interpretação dos dados coletados. Nessa fase trabalhou-se com os referenciais de integralidade no cuidado e de cogestão em saúde.

Com o intuito de preservar o anonimato, as Unidades de Saúde foram identificadas com nomes fictícios: a eSF Diamante, eSF Safira, UBS Rubi e UBS Esmeralda.

Quadro 1 – Apresentação dos temas e núcleos de sentido das entrevistas com profissionais da ESF e UBS, Marília, São Paulo, Brasil, 2020.

Temas	Núcleos de sentido
Desafios e propostas para atuação dos profissionais da ESF na Rede de Atenção à Saúde e Rede Cegonha	-Dificuldades na transição do modelo biomédico para ESF; -Desarticulação entre os diferentes serviços da Rede de Atenção à Saúde e Rede Cegonha; -Necessidade de ampliação do número de profissionais e reconhecimento do seu trabalho; -Necessidade de clareza na definição de papéis e protocolos; - Importância de ações de educação em saúde;
Desafios e propostas para atuação dos profissionais da UBS na Rede de Atenção à Saúde e Rede Cegonha	-Organização do processo de trabalho dificulta a operacionalização de ações de promoção e prevenção à saúde; -Divergência de orientações e fluxos entre os profissionais da equipe da AP; - Desarticulação entre os diferentes serviços da Rede de Atenção à Saúde e Rede Cegonha; -Desconhecimento sobre políticas públicas por parte dos profissionais e gestantes; -Insuficiência de recursos estruturais e organizacionais; - Importância de ações de educação em saúde e o número reduzido de profissionais; -Necessidade de qualificar os profissionais para o cuidado humanizado; -Necessidade de ampliação do número e de variedade de profissionais; -Intensificar ações preventivas para impactar nos Indicadores de saúde;

Fonte: dados da pesquisa

Este artigo é parte de uma dissertação de mestrado profissional, aprovado pelo Comitê de Ética em Pesquisa (CEP) e anuência do Comitê de Avaliação de Pesquisa da Secretaria da Saúde (COMAP), com registro CAAE: 02874218600005413 e parecer nº 3.123.730.

2. RESULTADOS

A seguir serão apresentados os temas e os núcleos sentido identificados a partir das falas dos profissionais da eSF e UBS.

2.1 Desafios e propostas para atuação dos profissionais da ESF na Rede de Atenção à Saúde e Rede Cegonha.

Um dos desafios vivenciados pelas eSF é a mudança do modelo curativista para o de prevenção de doença e promoção da saúde, pois os usuários dos serviços demandam urgência no cuidado e acreditam na potência da medicação na resolução dos seus problemas. Os profissionais referem que isso ocorre devido a dificuldade de compreensão das pessoas. Além, desse, a vigência dos dois modelos de Atenção à Saúde no município, também dificulta a implantação da ESF, fragilizando a RA e RC (Oliveira et.al.,2021)

> *"As pessoas elas são muito urgentes [...] procuram um modelo mais curativista, quero um remédio e ponto[...]. É falta do entendimento, é urgência do cuidado. E como tem os dois modelos de assistência [no município], UBS é diferente de Estratégia. [...] dificulta um pouco, pelo próprio entendimento"*. (Equipe SF Diamante).

Os entrevistados apontam que a perspectiva é desenvolver uma prática com qualidade, mas não atingem esse objetivo devido a falta de tempo em função da alta demanda, pois houve aumento de usuários SUS-dependente. E, mais, pelo número insuficiente de trabalhadores de saúde na eSF.

> *"[...] a gente acaba não tendo tempo suficiente para trabalhar com a qualidade que a gente queria, porque a demanda é muito grande, a população está muito mais "SUS-dependente" [...] , a gente não tem hoje em dia a quantidade de profissionais suficientes".* (Equipe SF Diamante)

As equipes do Núcleo de Apoio à Saúde da Família (NASF) não têm uma frequência estabelecida nas unidades, perdendo as características da ESF. Ainda assim, o Hospital Secundário contactua com os serviços da APS a fim de constituir a RAS. Em relação ao NASF, esse realizou grupos de orientação e ou operativo em parceria com diferentes profissionais da eSF, pois essa atividade era considerada primordial para se operacionalizar os princípios da ESF. No entanto, atualmente essa ação não é considerada essencial.

> *"No NASF não temos frequência nas Unidades e a estratégia que é perdido, um pouco a característica de Estratégia [...] a Estratégia não consegue mais desempenhar seu papel. O Hospital Secundário continua trabalhando dentro de um fluxo possível [...], quando fala de Estratégia a gente pensa [...] fala de grupo, isso não é mais assim, já não era tão assim, mas existia um pouco mais. Hoje a demanda é maior e a rotatividade de profissional também.* (Equipe SF Diamante)

Nesse contexto, os profissionais da eSF sinalizam que convivem com um modelo que está valorizando a produção quantitativa de "procedimentos" e não o cuidado integral da gestante, sendo influenciado e determinado pelo número reduzido de profissionais da equipe e do NASF, além da rotatividade desses, não constituindo, assim, possibilidade de construção de vínculo entre os profissionais para a efetivação do trabalho em equipe, buscando a intencionalidade de reconstrução das práticas.

Os profissionais que compõe as eqSF reconhecem a importância dos grupos de orientação e ou operativo as gestantes, apesar da baixa adesão quando realizado. No conjunto de depoimentos, afirmam ser necessário utilizar atrativos ou ter a participação do médico para que aumente o número de gestantes.

> *"O grupo é muito importante [...] é a adesão que é baixa da população, tem que ter alguma coisa muito chamativa para eles comparecerem nos grupos[...]os grupos que mais comparecem quando falamos que o médico vai estar presente ou quando vai ganhar alguma coisa".* (Equipe SF Diamante)

Os profissionais referem que com a implantação do e-SUS (Sistema de Saúde Eletrônico), houve melhora das informações dos usuários, permitindo acessos às redes de atendimento e aos registros da produção de cada profissional da APS para algumas especialidades. No entanto, não há um fluxo efetivo estabelecido de referência e contrarreferência e anotação na carteira da gestante dos atendimentos realizados. Compreendem que a interdisciplinaridade é importante para o atendimento integral da gestante em todos os âmbitos da Atenção à Saúde. A exceção é o hospital de referência secundária, como mencionado acima. Apontam para a necessidade de criar ambulatório de risco intermediário para suprir a dificuldade de comunicação com o de alto risco bem como melhorar o funcionamento desse último.

> *"Com o E-SUS tem melhorado para algumas especialidades, porém não funciona nos hospitais [...] a comunicação [...] dos dois lados. Facilitar esse canal porque é muito difícil a integração da rede mesmo, principalmente, por que o sistema não é o mesmo então não tem como ter outra informação, a não ser que alguém passe para a gente.*

> *Diferente no hospital[...], eu consigo ver porque é o mesmo sistema. A comunicação é importante".* (Equipe SF Safira)
>
> *"Em todos os âmbitos de atenção, eu acredito que a interdisciplinaridade no momento de avaliar, de fazer as necessidades de saúde, vão ser importantes".* (Equipe SF Safira)
>
> *"Não existe a contrarreferência. Todos querem que nós referenciemos para eles, contra referenciar para saber o que foi feito com o paciente, nunca".* (Equipe SF Diamante)
>
> *"Falta um ambulatório de médio risco e risco intermediário, e falta um ambulatório de alto risco melhor, por que o ambulatório de alto risco de Marília é bem complicado[...] com o ambulatório de risco intermediário, uma boa parte dessas dificuldades que a gente tem com o alto risco já ia se resolver ".* (Equipe SF Safira)

Também há fragilidades de comunicação entre os membros da própria eSF e dessa com a Secretaria Municipal de Saúde (SMS) para discussão dos casos, dificultando a construção do vínculo. Apontam a inexistência de implantação de protocolos para o cuidado gestantes no município e acréscimo de novos exames com definição de parâmetros para os encaminhamentos aos diferentes serviços de saúde de modo a facilitar a criação de fluxos efetivos na promoção do cuidado.

> *"Eles também são muito sobrecarregados lá, por que eles (SMS) têm também que atender o município inteiro, e não é só coisa de gestante, são várias outras coisas [...] toda hora eles também (SMS) estão em reunião, estão conversando com alguém, falta esse vínculo".* (Equipe SF Safira)
>
> *"É complicado essa parte de ligar e discutir (com a Área técnica da Saúde da Mulher na SMS)[...], por que quando a gente tem (dúvidas) a gente liga, aí não tem ninguém ou se tem alguém tá ocupado: você liga depois?[...] é muito difícil para a gente, por que como a gente não sabe para onde manda essa gestante, por que não tem o nível de complexidade que ela precisa, a gente tem que ficar ligando discutindo o caso toda hora"*. (Equipe SF Safira)
>
> *"Não existe um protocolo do município [...], o protocolo B é uma coisa que já colhe [...] aqui, no município, não existe [...] tem diabética que fica gestante e a gestante que fica diabética, e tem o nível de risco dessa paciente [...]. Tem paciente que tem indicação de insulina e tem a paciente que é diabética, mas não é complexa, para onde gente manda isso?"*. (Equipe SF Safira)

Além disso, sinalizam que o parto humanizado não está presente, sendo necessário formar os profissionais para tanto.

> *"Acho que falta um pouco do preparo na humanização do parto, a gente ouve muito falar de parto humanizado [...] mas não tem parto humanizado".* (Equipe SF Safira)

2.2 Desafios e propostas para atuação dos profissionais da UBS na Rede de Atenção à Saúde e Rede Cegonha.

Os trabalhadores de saúde afirmam que a APS tem entre suas atribuições, a prevenção por meio dos grupos, como, por exemplo, o de gestantes e puérperas, porém devido a "queixa aguda" da população, que demanda rápida resolubilidade, e o número reduzido de profissionais, o desenvolvimento dos mesmos deixa de ser prioridade para a equipe.

> *"A Atenção Primária prevê lidar muito com a prevenção e a gente acaba não tendo recurso para fazer realmente prevenção acontecer, por meios de grupo [...] aqui nós temos muitas gestantes e esse trabalho poderia ser feito [...] mas falta profissional [...] nós temos uma queixa aguda que precisa de resolutividade rápida, os grupos sempre acabam ficando para segundo plano, informação acaba ficando em segundo plano".* (Equipe UBS Esmeralda)

Os profissionais que compõe as equipes das UBS relatam que um dos desafios é a comunicação e o fluxo da APS com a Atenção Secundária. Consideram que se o usuário for encaminhado da APS para o hospital, esses reencaminham para o Pronto Atendimento (PA) da APS. No entanto, o serviço secundário possui como propósito a alta qualificada, mas, também apresentam dificuldade de operacionalização. Assim, dificilmente, os serviços da APS recebem essa contrareferência.

> *"Me ensinaram que, se precisar procurar o HM, que é a referência para gestante, não ocorre isso. Porque a pessoa vai lá e eles mandam voltar para o PA. Então eu acho que isso não está bem estabelecido, triado".* (Equipe UBS Rubi)
>
> *"O Hospital Secundário trabalha muito com alta qualificada, eles procuram trabalhar com essa ferramenta, mas eles não têm muita 'perna' para fazer todos os pacientes. Então, isso acaba acontecendo raramente".* (Equipe UBS Esmeralda)

Há falta de informação dos profissionais e das gestantes sobre as políticas públicas e não existe capacitação para os trabalhadores a respeito dessa temática.

> *"A falta de informação, tanto da população quanto dos profissionais, acerca da política pública, não é trabalhada, capacitada, nunca vi alguém capacitar uma equipe em política pública"*. (Equipe UBS Esmeralda)

Apontam também a falta de recursos estruturais e organizacionais como: oferta de exames, incompetência administrativa e não disponibilidade dos gestores em transformar o atual cenário.

> *"No município [...] dois mil de ultrassom atrasados, de Raio X, levantamento de todas as unidades [...] se for para ressonância [...]".* (Equipe UBS Esmeralda)
>
> *"Existe incompetência dos nossos gestores [...] não é financeiro, mas existe incompetência administrativa [...]. Nós estamos abandonados".* (Equipe UBS Esmeralda)

No conjunto de depoimentos, há sugestão de aumentar a quantidade de profissionais, em todas as categorias.

> *"A sugestão é o seguinte: mais médico, mais profissional, assistente social, nutricionista, acho que resolveria um dos problemas, mas não temos os profissionais suficientes na rede".* (Equipe UBS Rubi)

Os profissionais apontam que a unidade de saúde não está cumprindo o seu papel de promover ações de cunho preventivo, como por exemplo, não realizam visita domiciliar. E, mais, não geram indicadores que permitam conhecer as pessoas para o desenvolvimento dessas atividades. Acreditam que essas são atribuições da APS e que não as cumprem devido à falta de recursos.

> *"O preventivo seria mais a função da USF, a visita domiciliar que tem que fazer, onde tem que ir, tomar vacina, preventivo seria a USF [...] também está parado, não está cumprindo a função dele. A única coisa que faltou são os indicadores, a gente não consegue gerar indicadores devido essa falta de recursos [...] precisa gerar indicadores para reconhecer aquela população: preciso trabalhar a prevenção, a sífilis [...] com essa falta de recursos que a gente não consegue realmente cumprir o papel da Atenção Primária".* (Equipe UBS Esmeralda)

3. DISCUSSÃO

Um dos desafios centrais vivenciado pelas equipes da APS são as mudanças do modelo de atenção à saúde. Convive-se com o modelo biomédico e o de vigilância à saúde, produzindo diversos entendimentos acerca de como implementar as ações propostas na RC.

No município pesquisado, percebeu-se que a gestante tem acesso para iniciar o seu cuidado tanto com a eSF como na UBS. Porém, a realização do cuidado ainda apresenta dificuldades para que ocorra em equipe, incluindo o NASF, sendo um dos determinantes a defasagem de número de profissionais para desenvolver as ações propostas.

Percebe-se, também, o desafio de se construir com as gestantes uma prática focada na promoção à saúde e prevenção de agravos. Sinalizam que as gestantes requerem práticas ancoradas no modelo biomédico, no entanto, essa transição de modelo de cuidado se faz em processo entre os profissionais, gestores, assim como com as gestantes.

A concepção das gestantes sobre o cuidado em saúde está alicerçada no modelo biomédico, evidenciado por meio da maior valorização das consultas médicas e dos procedimentos de tecnologias duras realizados, centralizando a sua produção em saúde no ato médico e poderá desconsiderar ações coletivas ou de outros profissionais na construção do cuidado na assistência pré-natal. Fogaça et al. (2017), afirma que o posicionamento das gestantes poderia ser diferenciado se houvesse o entendimento do seu papel como coparticipante na produção do seu cuidado durante a elaboração do plano de cuidados nas consultas de pré-natal

Compreende-se que o modelo biomédico foi constituído socio-culturalmente com as pessoas ao longo de décadas, sua desconstrução requer ações pactuadas entre gestores, profissionais e comunidade, além de envolver a formação profissional, num movimento de cogestão. O enfoque está na análise do trabalho enquanto atividade concreta, compreendendo como os coletivos operam cotidianamente, quais são os ensinamentos entre os segmentos, como se articulam e se reinventam (Santos & Ventura, 2021).

Com o aumento de usuários que dependem do acesso ao SUS, trabalha-se muito mais em função da quantidade de atendimentos agendados e demanda de gestantes, adultos, criança, adolescente, hipertensos, diabético, idoso, não conseguindo fazer visitas. Nesse contexto, os profissionais da eSF sinalizam que convivem com um modelo que está valorizando a produção quantitativa de "procedimentos" e não o cuidado integral da gestante, sendo influenciado e determinado pelo número reduzido de profissionais da equipe e do Núcleo Ampliado de Saúde da Família (NASF), mas também com rotatividade desses, não constituindo, assim, possibilidade de construção de vínculo entre os próprios profissionais para a efetivação do trabalho em equipe, buscando a intencionalidade de reconstrução das práticas.

A disponibilidade de profissionais em quantidade suficiente humaniza e qualifica a oferta do cuidado. Escutas qualificadas fortalecem o vínculo com as gestantes assistidas no pré-natal (Silva et al., 2018).

Ou seja, mesmo que ocorra um esforço por parte das equipes em realizar mudanças na organização do cuidado às gestantes, há uma proposição da política pública em estruturar as práticas voltadas para a produção quantitativa em detrimento a busca pela qualidade ancorada na integralidade do cuidado.

Percebe-se um retrocesso do modelo assistencial da ESF e das equipes multiprofissionais nas políticas da APS, com a redução dos profissionais que atuam em unidades de saúde. Novos moldes de organização foram permitidos a partir do Programa Nacional Atenção Básica (PNAB) 2017, no Brasil, com a redução e até a ausência do NASF e de Agentes Comunitários de Saúde (ACS) nas equipes e influencia a concepção da determinação social do processo saúde-doença e da clínica ampliada. O médico poderá reduzir sua carga horária de trabalho e seu trabalho tende a ser voltado a ações curativistas e individualizadas (Giovanella, Franco & Almeida, 2020).

A extinção de credenciamento e financiamento federal dos NASF evidencia outro ponto de involução. O conceito de multiprofissionalidade e interdisciplinaridade tendem a desaparecer, pois a prioridade será o cuidado individual e o atendimento à demanda espontânea. Segundo Giovanella et al. (2020), há a tendência da ESF ser descaracterizada em seu processo de trabalho, da capilaridade das equipes nas comunidades e organização das ações. Poderá comprometer a longitudinalidade e coordenação do cuidado, desarticulada com as redes de urgência e direcionando às demandas agudas e manejo de doenças, com monitorização de casos graves a espera de transferência. Considerar apenas a população cadastrada, na prática, significa romper com a universalidade e equidade do SUS.

Os profissionais que compõe as equipes da APS relatam que um outro desafio é o cuidado em rede, pautado na integralidade como princípio norteador, ou seja, a comunicação da APS com Atenção Secundária e a Atenção Hospitalar, entre os membros da própria eSF e dessa com a SMS para discussão dos casos, além da dificuldade na existência de contrarreferência por parte da atenção hospitalar.

Estas equipes que são responsáveis pela produção do cuidado apontam a inexistência de implantação de protocolos para gestantes no município e acréscimo de novos exames com definição de parâmetros para os encaminhamentos e locais de parto, identificação dos fluxos efetivos de atendimento do município.

Os profissionais compreendem que a interdisciplinaridade é importante para o atendimento integral da gestante e em todos os âmbitos da Atenção à Saúde. Afirmam que o hospital de referência secundária trabalha dentro de um fluxo possível com discussão de alguns casos criando redes dentro das unidades de saúde da APS.

Com a implantação do sistema eletrônico de registro dos dados no SUS (e-SUS), houve melhora das informações dos usuários, permitindo acessos às redes de atendimento e aos registros da produção de cada profissional da APS para algumas especialidades. No entanto, ao não se ter um fluxo efetivo estabelecido de referência e contrarreferência e anotação na carteira da gestante dos atendimentos realizados, o trabalho em rede continua comprometido. Para tanto, sugerem que se tenha a formação dos profissionais sobre as políticas públicas da RAS e RC, para que possam, junto aos gestores, estabelecer a reorganização do cuidado.

A organização da RAS e da RC é imprescindível para um cuidado humanizado e voltada à integralidade do cuidado, garantindo acesso, acolhimento e resolutividade (Silva et al., 2018). As gestantes em acompanhamento nas unidades de saúde vivenciam diferentes cenários, que requerem diferentes olhares.

Os profissionais elencam como propostas de superação dos desafios a necessidade de melhorar a definição dos papéis e os protocolos dos serviços de saúde, visando a integração no cuidado e criando o ambulatório de risco intermediário ou de média complexidade para discussão de casos que gerem dúvidas aos profissionais.

Uma proposição seria redesenhar as Regiões de Saúde e definindo-as como responsáveis pela gestão da média e alta complexidade e da Vigilância em Saúde, inclusive com a Atenção Hospital que tem sido operacionalizada, desconectada da APS e operarem com problemas de eficiência e efetividade.

Para contemplar as propostas apresentadas e sustentabilidade do SUS é necessária a formação de profissionais e de equipes multiprofissionais, que contemplem às necessidades de saúde dos territórios e seus contextos ao qual estão inseridos, e uma gestão com olhar voltado para este contexto. A prática interdisciplinar deve ser estimulada, bem como o compartilhamento de responsabilidades e de tarefas. Campos (2018) destaca que o processo de cuidado fragmentado, entre os serviços e a movimentação do usuário como uma peça deslizante, tem resultados desumanos, ineficazes e ineficientes. É fundamental que ocorra melhoria da comunicação e integração dos serviços para democratização e sustentabilidade do SUS e a expansão da ESF é uma estratégia a ser considerada.

CONCLUSÃO

Percebe-se que o trabalho em rede não tem funcionado no município, tendo deficiência com relação ao estabelecimento dos fluxos, com pouca capacidade de resolução das situações frente aos processos de comunicação formal, seja por sistema de referência e contrarreferência, ou mesmo entre os profissionais da equipe, que estão em número reduzido e tendo rotatividade tanto na equipe de referência e no NASF.

As propostas de superação dos desafios passam pela reconstrução dos fluxos, protocolos e comunicação entre os serviços, mas também com a gestão municipal da área da saúde da mulher proporcionar a construção coletiva da implementação da RC num movimento de cogestão.

É essencial um novo olhar para a dinâmica da centralização e descentralização das ações equilibradas nas Políticas Nacionais de Saúde, construídas e aprovadas pelos organismos de cogestão do SUS: Conferências, Conselhos e Comissões Tripartites. Há uma tendência recente de desmonte destas políticas, fragmentando ainda mais o SUS e expor as gestões estaduais e municipais à pressão de interesses de grupos externos em se aproveitar do SUS.

Reconhece-se a limitação do estudo ao bordar o cuidado em Rede em um município, porém, outras investigações são necessárias frente às novas políticas públicas implementadas no Brasil, o que gera desafios frente à proposta de integralidade no cuidado em saúde.

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OS IMPACTOS DE EVENTOS TRAUMÁTICOS ESPECÍFICOS DO GÉNERO NO BEM-ESTAR PSICOLÓGICO DAS MULHERES REFUGIADAS: UM PROTOCOLO DE REVISÃO DO ÂMBITO DE APLICAÇÃO

THE IMPACTS OF GENDER-SPECIFIC TRAUMATIC EVENTS ON REFUGEE WOMEN'S PSYCHOLOGICAL WELLBEING: A SCOPING REVIEW PROTOCOL

LOS IMPACTOS DE LOS EVENTOS TRAUMÁTICOS ESPECÍFICOS DE GÉNERO EN EL BIENESTAR PSICOLÓGICO DE LAS MUJERES REFUGIADAS: UN PROTOCOLO DE REVISIÓN DE ALCANCE

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RESUMO

Introdução: A migração forçada, em geral, compreende uma série de eventos traumáticos num período multifásico prolongado; no entanto, as mulheres refugiadas suportam tipicamente eventos traumáticos específicos do género durante sua jornada migratória. Apesar dos típicos impactos negativos relatados dos eventos traumáticos, a literatura também identifica mudanças positivas pós-traumáticas como bem-estar psicológico pós-traumático.
Objetivo: Identificar sistematicamente os eventos traumáticos baseados no género ao longo da jornada migratória e o impacto destes eventos no bem-estar psicológico das mulheres refugiadas pós-traumáticas
Métodos: O PRISMA Extension for Scoping Reviews (Tricco et al. 2018) e o Joanna Briggs Institute Manual for Evidence Synthesis (Peters et al. 2020) orientarão esta revisão. Por conseguinte, será revista sistematicamente a literatura académica e cinzenta extraída de PsycInfo, PubMed, Embase, SCOPUS, CINAHL, assim como Open Grey e Google Scholar. A estratégia de pesquisa consistirá em sinónimos para as três construtores básicos: eventos traumáticos específicos do género, bem-estar psicológico, e mulheres refugiadas. Dois revisores irão rever e extrair resultados de estudos qualitativos, quantitativos, e de métodos mistos. Os resultados serão codificados e apresentados tematicamente utilizando a versão NVivo 11.
Resultados: Os eventos traumáticos identificados com base no género ao longo da jornada migratória e o impacto destes eventos no bem-estar psicológico pós-traumático das mulheres refugiadas serão apresentados de forma exaustiva no relatório completo.
Conclusão: Os resultados identificarão conceitos-chave, as lacunas da investigação e os tipos e fontes de provas para compreender o bem-estar psicológico das mulheres refugiadas após a sua reinstalação

Palavras-chave: bem-estar psicológico; refugiado; eventos traumáticos específicos do género; mulher/mulheres

ABSTRACT

Introduction: Forced migration, in general, comprises a series of traumatic events in a prolonged multiphase period; however, women refugees typically endure gender-specific traumatic events through their migration journey. Despite the typical reported negative impacts of traumatic events, the literature also identifies positive posttraumatic changes as posttrauma psychological wellbeing.
Objective: To systematically identify the gender-based traumatic events throughout the migration journey and the impact of these events on the refugee women's posttrauma psychological wellbeing
Methods: The PRISMA Extension for Scoping Reviews (Tricco et al. 2018) and the Joanna Briggs Institute Manual for Evidence Synthesis (Peters et al. 2020) will guide this scoping review. Therefore, it will systematically review academic and grey literature extracted from PsycInfo, PubMed, Embase, SCOPUS, CINAHL, as well as Open Grey and Google Scholar. The search strategy will consist of synonyms for the three basic constructs: gender-specific traumatic events, psychological wellbeing, and women refugees. Two reviewers will review and extract results from qualitative, quantitative, and mixed methods studies. The results will be coded and presented thematically using NVivo version 11.
Results: The identified gender-based traumatic events throughout the migration journey and the impact of these events on the refugee women's posttrauma psychological wellbeing will be comprehensively presented in the full report.
Conclusion: The findings will identify key concepts, the research gaps, and types and sources of evidence to understand refugee women's psychological wellbeing post-resettlement.

Keywords: psychological wellbeing; refugee; gender-specific traumatic events; woman/women

RESUMEN

Introducción: La migración forzosa, en general, comprende una serie de acontecimientos traumáticos a lo largo de un período prolongado de varias fases; sin embargo, las mujeres refugiadas suelen sufrir acontecimientos traumáticos específicos de su género durante su viaje migratorio. A pesar de los típicos impactos negativos reportados de los eventos traumáticos, la literatura también identifica cambios postraumáticos positivos como el bienestar psicológico postraumático.
Objetivo: Identificar sistemáticamente los acontecimientos traumáticos basados en el género a lo largo del viaje migratorio y el impacto de estos acontecimientos en el bienestar psicológico de las mujeres refugiadas postraumáticas.
Métodos: La Extensión PRISMA para Revisiones de Alcance (Tricco et al. 2018) y el Manual de Síntesis de la Evidencia del Instituto Joanna Briggs (Peters et al. 2020) guiarán esta revisión. Por lo tanto, se revisará sistemáticamente la literatura académica y gris extraída de PsycInfo, PubMed, Embase, SCOPUS, CINAHL, así como Open Grey y Google Scholar. La estrategia de búsqueda consistirá en sinónimos para los tres constructores básicos: eventos traumáticos específicos de género, bienestar psicológico y mujeres refugiadas. Dos revisores revisarán y extraerán los resultados de los estudios cualitativos, cuantitativos y de métodos mixtos. Los resultados se codificarán y presentarán temáticamente utilizando NVivo 11.
Resultados: Los acontecimientos traumáticos de género identificados a lo largo del viaje migratorio y el impacto de estos acontecimientos en el bienestar psicológico postraumático de las mujeres refugiadas se presentarán de forma exhaustiva en el informe completo.
Conclusión: Los resultados identificarán los conceptos clave, las lagunas en la investigación y los tipos y fuentes de pruebas para comprender el bienestar psicológico de las mujeres refugiadas tras el reasentamiento.

Palabras Clave: bienestar psicológico; refugiado; eventos traumáticos específicos de género; mujer/mujeres

INTRODUCTION

Worldwide, the refugee population is at its highest since World War II (The U.N. Refugee Agency, 2019). More than two-thirds of refugees (67%) are from the Middle East, South America, and Africa (United Nations Higher Commissionaire for Refugees [UNHCR], 2020). Women reportedly constitute half of the world's refugee population (The U.N. Refugee Agency, 2019; UNHCR-women, 2021) and are regarded as one of the world's most vulnerable groups and the world's biggest minority. They are predominantly from patriarchal societies (UNHCR, 2017).

Women are more likely to experience an array of unique gender directed traumatic events throughout their life span (Olff, 2017). In the case of refugee women, their experience of traumatic events throughout the migration journey have been found to impact their psychological wellbeing post-resettlement (Schweitzer et al., 2018).

1. REVIEW OF LITERATURE

In past decades, attempts to clarify what constitutes a potentially traumatic event and its impact on individuals have provided a lexicon of interpretations that often create confusion (Courtois et al., 2009; McCormack & Thomson, 2017). The American Psychiatric Association (2013) defines trauma as actual or threatened death, serious injury, or sexual violence. Many studies differentiate between single incidence trauma, cumulative non-interpersonal traumas, cumulative interpersonal traumas or complex traumas (Kira, 2001; McCormack et al., 2021). A variety of reactions have been reported following exposure to traumatic events indicating that individual experiences fall on a spectrum from none to severe (Briere, Agee & Dietrich, 2016; Weathers & Keane, 2007); and the adaptation process may either result in assimilation or accommodating negative and positive posttrauma changes (Joseph & Linley, 2005).

The psychopathological impacts of gender-based trauma in women refugees include but are not limited to posttraumatic stress disorder (Vallejo-Martín et al., 2021), depression and anxiety (Hossain et al., 2021). However, Joseph and Linley's (2005) organismic valuing process theory (OVP) defines positive changes after exposure to traumatic events as growth out of adversity. This is seen as changes in appreciation of self, relations with others, and changes in worldview. Perceived or real posttrauma psychological wellbeing encompasses self-acceptance, environmental mastery, personal growth, autonomy, positive relations with others, and a purpose in life (Ryff, 1989; Ryff & Singer, 1996). Therefore, an overview of literature assists in understanding refugee women's posttrauma psychological wellbeing.

A scoping review will better identify, map and synthesise the available evidence and pinpoint knowledge gaps while capturing the breadth of literature that reports on the journey of refugee women, potentially traumatic experiences, and their impact on the posttrauma psychological wellbeing of women refugees. The purpose of the review is to provide an overview of literature rather than informing clinical guidelines or practices (Peters et al., 2020) by answering the research question:

- to synthesise the literature concerning gender-specific trauma and psychological wellbeing changes in refugee women in the aftermath of the refugee journey and provide an opportunity to identify key concepts, gaps in the research, and types and sources of evidence (Arksey & O'Malley 2005).

2. METHODS

2.1 Study design

Grant and Booth (2009) define Scoping review as a "preliminary assessment of potential size and scope of available research literature. They aim to identify the nature and extent of research evidence (usually including ongoing research)." A scoping review seeks a more inclusive breadth of commentary than traditional systematic reviews with correspondingly a more expansive inclusion criteria to identify knowledge gaps, scope a body of literature, clarify concepts, or investigate research conduct. This scoping review intends to report the breadth of research and identify knowledge gaps to update research areas. Therefore, the authors will utilise the PRISMA extension for Scoping Reviews (PRISMA-ScR) tool and seek advice from The Joanna Briggs Institute Manual for Evidence Synthesis (Peters et al., 2020). The current scoping review intends to present a descriptive report of the reviewed material deprived of analytically assessing individual studies or integrating evidence from different research (Brien et al., 2010); therefore, no bias is involved. Therefore, the quality assessment and critical appraisal of the risk of biases are not required in the current scoping review (Peters et al., 2020).

2.2 Data collection instruments

The authors screened the electronic databases based on the topic, and the most applicable databases with the most coverage were underscored as PsycInfo, PubMed, Embase, SCOPUS, and CINAHL.

A broad list of synonyms related to each of the three constructs (gender-specific traumatic events, psychological wellbeing, women refugees) was prepared based on titles, abstracts, and index terms of relevant studies (see Table 1).

Table 1 - Full list of search terms and synonyms for each of the three research constructs

Gender-Specific Traumatic Events	**Psychological Wellbeing**
Trauma	Psychological wellbeing
Psychological or Mental distress	Autonomy
Genocide or Ethnic cleansing or Ethnic minority or Racism or Exile	Environmental mastery
Torture or Abuse or Violence	Personal growth
Combat Experience or War or Armed conflict or Survivor or Victim	Positive relations with others or Positive relationships
Assault or harassment or rape	Purpose in life
Human trafficking	Self-acceptance
Neglect	Posttraumatic growth
Natural disaster	Growth out of adversity or Adversarial growth
Forced marriage	Thriving
Persecution	Meaning-making
Loss or Death	
Betrayal	
	Women Refugees
	Refugee
	Forced migration
	Humanitarian migration
	AND
	Female
	Girl
	Woman or women
	Spouse
	Wife or wives
	Widow
	Mother

A Boolean search with truncations and wildcards will be used for the scoping review as follows:

- *Population (Women Refugees):* (Female or Girl or Wom?n or Spouse* or Wife or Wives or Widow* or Mother*) AND (Refug* or Forced migrat* or Humanitarian migrat*) AND *Concept (Gender-specific traumatic events):* (Trauma* or Psychological distress or Mental ill* or Mental disorder* or Mental disease* or Posttraumatic stress disorder or Genocide or Ethnic cleansing or Ethnic minority or Racism or Exile or Tortur* or Abus* or Violen* or Combat Experience* or War* or Armed conflict or Surviv* or Victim* or Assault or Harassment or Rap* or Human trafficking or Negl* or Natural disaster* or Forced marriage or Persecut* or Loss or Death or Betray*) AND *Context (Psychological wellbeing):* (Psychological wellbeing or Autonomy or Environmental mastery or Personal growth or Relation* with other* or Positive relation* or Purpose in life or Self-acceptance or Posttrauma* growth or Growth out of adversity or Adversarial growth or Thriving or Meaning-mak*) - *Limiters:* Years 1992 –2022; human studies only

According to the PRISMA flow diagram, the additional hand-searched and suggested studies will be screened for inclusion. Therefore, the first Author will perform the final manual reference screening on the included full-text papers to identify any probable missing articles. Likewise, the Author will search Open Grey and Google Scholar for acceptable grey literature. Lastly, in case of requiring more information, the Author will seek the professional recommendations of experts and associations.

2.3 Requirements (inclusion and exclusion criteria)

2.3.1 Inclusion

2.3.1.1 Participants

This scoping review will include studies inclusive to refugees with the background of forced or involuntary displacement from the unique perspective of women refugees.

2.3.1.2 Concept

Refugees' trauma narratives often describe horrific events directed at stateless individuals in vulnerable situations (McCormack & Tapp, 2019; McCormack & Strezov, 2020), often reported as cumulative and complex traumas. In addition, gender often plays a part in the type of traumatic threat (Olff, 2017). Women endure and report more frequent interpersonal incidents and sexual assaults than men (Gavranidou & Rosner, 2003, p.132), and different types of traumas experienced by women generate different reactions and are most likely to give rise to ongoing psychological complications (Bowers, 2009, p.14). Gender-specific traumatic events refer to gender-specific types of distressing events. As a result, the current scoping review seeks the type and severity of traumatic events experienced by women refugees pre, during and post-migration.

2.3.1.3 Context

Diverse cultures refer to psychological wellbeing differently. Refugee women's studies need to be considered from within their cultural context to understand the impact of the migration journey, including gender-based traumatic events, and how women respond psychologically to these events. For many refugee women, there is no personal choice as many come from minority groups and patriarchal systems (United Nations High Commissioner for Refugees [UNHCR], 2017). Therefore, they are likely to be exposed to potentially traumatic events from a position of powerlessness and vulnerability (United Nations High Commissioner for Refugees [UNHCR], 2017). However, Hutchinson and Dorsett (2012) note that refugee women demonstrate resilience through adapting and coping post-resettlement despite facing tremendous challenges. Resiliency is the ability to resist negative change and return to the level of the psychological functioning present before traumatic events (Bonanno, 2004) rather than posttrauma thriving inclusive of behaviours and thought patterns not necessarily present prior to exposure to trauma (Turner & Cox, 2004).

This scoping review will include studies on posttrauma psychological wellbeing, as opposed to subjective wellbeing, involving changes in self-acceptance, environmental mastery, personal growth, autonomy, positive relations with others, and a purpose in life, during the post-resettlement stage. This scoping review will include studies that holistically refer to growth or positive posttrauma changes rather than resilience and psychopathology from a non-Western perspective.

2.3.1.4 Evidence sources/types of studies

Quantitative, qualitative, and mixed methods studies published in peer-reviewed journals about gender-specific traumatic events experienced by women refugees will be counted for inclusion. This scoping review will include primary studies in the past three decades, as posttrauma growth or positive changes after adversities began appearing in the trauma literature during the early-1990s; however, other systematic and literature reviews may conceivably be utilised to explore reference lists manually. Furthermore, the Author will search Open Grey and Google Scholar for acceptable grey literature. As it investigates the context of women refugees, this scoping review will include the government and NGO's statements, annual reports, fact sheets (e.g., Health and welfare department; U.N. Women), conference proceedings, theses, and dissertations with relevant data in various forms (e.g., pdf and presentation slides). Lastly, the reviewers will not apply any initial filters except limited to 'human studies' and 'years 1992 –2022' in the searching strategy, but as a note, the reviewers will exclude any studies without accessible English translation because of limited resources for translation.

2.3.2 Exclusion

In the current scoping review, the reviewers will exclude studies if they solely focus on voluntary migration or refugee-like status inclusive of asylum seekers, stateless people, and displaced individuals, even though the study includes traumatic events and posttrauma psychological wellbeing. Moreover, the reviewers will exclude studies if they do not singly report on the impacts of gender-specific traumatic events on posttrauma psychological wellbeing and its dimensions. Ultimately, the reviewers will exclude studies if they do not separately analyse and report findings about women refugees.

2.4 Procedures

2.4.1 Screening process/ study selection

The Authors use Covidence to export articles from searching databases, checking references, and the recommendations. After duplicates are removed automatically, the studies will move to the titles and abstracts screening section in Covidence. In this level, two reviewers will screen the title and abstract of each study separately. As a pilot screening, the reviewers will screen 25 randomly chosen studies for quality and consistency in screening to discuss conflicts and clarify any inclusion or exclusion criteria accordingly. The research team will develop a title and abstract relevance screening table (see Table 2) to provide a clear screening outline.

Table 2 - Title and abstract relevance screening form

Selection Criteria	Inclusion Criteria	Exclusion Criteria
Participants	** Refugees refer to individuals with forced or involuntary displacement backgrounds in the post resettlement stage ** women refer to individuals older than 18	**Studies focus on voluntary or non-humanitarian migration or refugee-like populations -i.e., asylum seekers and stateless individuals **female under the age of 18
Concept	**Gender-specific traumatic events refer to traumatic events experienced by women refugees pre-, during-, and post-migration	** Studies do not specifically report on gender-specific traumatic events
Context	** Report on the impact of gender-specific traumatic events on the psychological wellbeing of women refugees in post resettlement stage, e.g., sexual assault impacts on personal growth	**Studies do not singly report on psychological wellbeing impacts of gender-specific traumatic events
Design	**Primary research/studies; additionally, relevant systematic or literature reviews that may be used for hand-searching reference lists **explore the gender-specific traumatic events impact on the posttrauma psychological wellbeing of women refugees. All 3 constructs: A) gender-specific traumatic events and psychological wellbeing and women refugees Or B) the combination of relevant synonyms of 3 constructs: e.g., institutional domestic violence, life purpose, refugee female **Relevant studies without available abstracts consider for the full-text screening	**Studies do not separately analyse and report findings about women refugees. **Studies without accessible full-text or full-text English translation **Non-human studies

Taheri, M., Fitzpatrick, S., & McCormack, L. (2022). The Impacts of Gender-specific Traumatic Events on Refugee Women's Psychological Wellbeing: A Scoping Review Protocol. *Millenium, 2*(18), 75-82.
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It assists in preventing the waste of resources in acquiring studies that will not take on the minimum inclusion criteria (e.g., the reviewers will include the presented potential studies without available abstract for subsequent review of the full-text screening). The actual title and abstract reviewing process will begin after the reviewers' agreement is greater than 75% over the screening process criteria. In the next level, the included title and abstracts will move to the full-text screening section in Covidence.

The reviewers will do the full-text screening, and another author will randomly select articles undergoing review to confirm revision based on the utilised inclusion and exclusion criteria. While the accepted studies will be extracted from Covidence for the scoping review analysis, a comprehensive table will be documented to justify the excluded articles after the full-text screening process in Covidence. The reviewers will contact each other to resolve any raised conflicts through the screening process, and this process is vital to ensure consistency between the reviewers with the research question and purpose. As a final note, two professional reviewers will be accessible to evaluate and revise any unresolved conflicts in the screening process.

2.4.2 Data extraction

The quality assurance will occur while the authors will individually conduct a pilot data extraction from 5 studies based on the customised template (see Table 3).

Table 3 - Data extraction tool

Author, year, title	
Study type	
Country of origin	
Country of study	
Study aims, objectives or purpose	
Population (incl age and sample size)	
Method	
Measures	
Gender-specific traumatic events- (incl trauma type and period)	
outcome(s)- posttrauma psychological wellbeing	
Results- quantitative or qualitative or mixed-methods	
Author recommendation for future studies	

After total agreement over the template and potentially revised template based on the pilot data extraction, each reviewer will separately extract the final data from the included studies in Covidence. The authors will stay in contact to deem any inconsistencies to attain a consensus throughout the process.

The authors will extract data based on the subsequent factors:

- author, year, title
- study type
- country of origin
- country of study
- study aims, objectives or purpose
- population (including age and sample size)
- method
- measures
- gender-specific traumatic events- trauma (including trauma types and period)
- outcome(s)- posttrauma psychological wellbeing
- results- quantitative or qualitative or mixed-methods
- Recommendations for future studies

3. RESULTS AND DISCUSSION

The current scoping review aims to synthesise the literature concerning gender-specific trauma and posttrauma psychological wellbeing in refugee women to identify key concepts, gaps in the research, and types and sources of evidence to inform practice using NVivo version 11. NVivo, in a mixed-method review, provides an organised and structured approach to offer thematical analysis. Therefore, relevant qualitative, quantitative, and mixed methods data around the topic will be extracted, thematically coded, and reported in the full scoping review as a descriptive narrative. The report includes gender-specific traumatic events pre-, during-, and post-migration and their impact on women refugees' posttrauma psychological wellbeing post-resettlement. Findings might be reported in tables, figures, and diagrams.

CONCLUSION

The final report will broadly represent the significance of the current scoping review, including understanding and offering a broad overview of refugee women's posttrauma psychological wellbeing.

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SUPERVISÃO CLÍNICA DO ENFERMEIRO NA COMUNIDADE PARA PROMOVER A QUALIDADE DO CUIDADO PRESTADO PELO CUIDADOR: PROTOCOLO DE REVISÃO DE ESCOPO

CLINICAL SUPERVISION OF THE NURSE IN THE COMMUNITY TO PROMOTE QUALITY OF CARE PROVIDED BY THE CAREGIVER: SCOPING REVIEW PROTOCOL

SUPERVISIÓN DE ENFERMERO EN LA COMUNIDAD PARA PROMOVER LA CALIDAD DEL CUIDADO PRESTADO POR EL CUIDADOR: PROTOCOLO DE REVISIÓN DEL ALCANCE

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RESUMO

Introdução: Os cuidadores geralmente não possuem conhecimentos e habilidades para prestar cuidados. Os enfermeiros têm um papel decisivo na qualidade dos cuidados e nos resultados na saúde das pessoas. A supervisão clínica do enfermeiro é um processo estratégico e formal que requer uma relação supervisiva coesa.
Objetivo: Mapear as estratégias de supervisão utilizadas pelo enfermeiro na comunidade para promover a qualidade do cuidado prestado pelo cuidador.
Métodos: Esta revisão seguirá as diretrizes do Instituto Joanna Briggs para revisões de escopo e incluirá estudos sobre enfermeiros que implementaram estratégias de supervisão clínica para promover a qualidade do cuidado prestado pelo cuidador em contexto comunitário. Estudos publicados e não publicados em inglês, português ou espanhol desde 1993 serão considerados. A seleção dos estudos será realizada por dois revisores independentes, utilizando um terceiro revisor em caso de discordância. Os resultados da pesquisa, seleção de estudos e processo de inclusão serão apresentados num fluxograma PRISMA para revisões de escopo. A extração dos dados, análise de evidências e resultados sobre a extensão e tipo de evidências serão apresentados numa tabela.
Resultados: A pesquisa bibliográfica prévia permitiu identificar algumas estratégias supervisivas implementadas por enfermeiros para promover a qualidade dos cuidados prestados pelo cuidador.
Conclusão: Esta revisão contribuirá para identificar estratégias de supervisão utilizadas pelos enfermeiros para promover a qualidade dos cuidados prestados pelos cuidadores.

Palavras-chave: supervisão de enfermagem; enfermeiras e enfermeiros; melhoria de qualidade; cuidadores; redes comunitárias

ABSTRACT

Introduction: Caregivers do not usually have the knowledge and skills to provide care. Nurses have a decisive role in the quality of care and people's health outcomes. Clinical supervision of nurses is a strategic and formal process that requires a cohesive supervisory relationship.
Objective: To map the supervisory strategies used by nurses in the community to promote the quality of care provided by caregivers.
Methods: This review will follow the Joanna Briggs Institute guidelines for scoping reviews and will include studies about nurses who have implemented clinical supervision strategies to promote the quality of care provided by caregivers in the community. Published and unpublished studies written in english, portuguese or spanish since 1993 will be considered. Study selection will be carried out by two independent reviewers, using a third reviewer in case of disagreement. The search results, study selection and inclusion process will be presented in a PRISMA flowchart for Scoping Reviews. Data extraction, analysis of evidence and results about the extent and type of evidence will be presented in a tabular form.
Results: The previous bibliographic research allowed the identification of some supervisory strategies implemented by nurses to promote the quality of care provided by the caregiver.
Conclusion: This review will contribute to identify supervisory strategies used by nurses to promote the quality of care provided by caregivers.

Keywords: nursing, supervisory; nurses; quality improvement; caregivers; community networks

RESUMEN

Introducción: Los cuidadores generalmente carecen del conocimiento y las habilidades para brindar atención. Enfermeros juegan un papel decisivo en la calidad del cuidado y en los resultados de salud. La supervisión clínica de enfermeros es un proceso estratégico y formal que requiere una relación supervisora cohesionada.
Objetivo: Mapear las estrategias de supervisión utilizadas por el enfermero en la comunidad para promover la calidad del cuidado prestado por el cuidador.
Métodos: Esta revisión seguirá las pautas del Instituto Joanna Briggs para las revisiones del alcance y incluirá estudios sobre enfermeros que hayan implementado estrategias de supervisión clínica para promover la calidad del cuidado prestado por el cuidador en la comunidad. Se considerarán las fuentes de información publicadas y no publicadas en inglés, portugués o español desde 1993. La selección de estudios será realizada por dos revisores, utilizando un tercer revisor en caso de desacuerdo. Los resultados del proceso de investigación, selección de estudios e inclusión se presentarán en un diagrama PRISMA. La extracción de datos, el análisis y los resultados sobre el alcance y el tipo de evidencia se presentarán en una tabla.
Results: La investigación bibliográfica previa permitió identificar algunas estrategias de supervisión implementadas por enfermeros para promover la calidad del cuidado prestado por el cuidador.
Conclusión: Esta revisión contribuirá a identificar las estrategias de supervisión usadas por enfermeros para promover la calidad del cuidado prestado por los cuidadores.

Palabras Clave: supervisión de enfermería; enfermeras y enfermeros; mejoramiento de la calidad; cuidadores; redes comunitarias

INTRODUCTION

In 2005, an estimated 19 million people in the European Union spent at least 20 hours a week caring for elderly, disabled or chronically ill individuals. The role of caregiver has assumed great importance, and it is expected to increase by 13% by 2030 (Glendinning et al., 2009). A recent report indicates that the percentage of informal care in several European countries varies between nine and 34% (European Commission, 2018). According to the data, the majority of caregivers are women over the age of 35 (European Commission, 2018).

Nurses are the health professionals closest to people, families and the community and working as a decisive factor in people's health outcomes. The relationship between a nurse and the person being cared for is imperative to allow a thorough assessment of the situation and context, the identification of priorities and the formulation of an action plan (International Council of Nurses [ICN], 2020).

As a universal need, nursing care encompasses several aspects, including the promotion of health, prevention of illness, care of the ill and disabled, reduction of suffering and promotion of a dignified death (ICN, 2021). Moreover, nurses are in a uniquely privileged position to care for, promote well-being and quality of care within a safe environment (ICN, 2021).

The ICN (2021) and the World Health Organization (WHO, 2021) advocate that the future vision of health care requires nurses' active participation, involvement, and training in decision-making. Nurses in research, education and clinical practice are part of the answer to many challenges aimed at transforming health systems. The Clinical Supervision of Nurses (CSN) emerges as an approach capable of transforming health systems (Pollock et al., 2017).

CSN is a professional relationship between supervisor and supervisee. During the supervision process, the supervisor ensures learning opportunities, supports and guides the supervisee in developing skills and competencies based on critical thinking and reflection. This is a formal, dynamic, sequential and demanding process that makes clinical nursing practice more meaningful and ethical by promoting safety, quality of care and well-being (Lynch et al., 2008; O'Shea et al., 2019).

Originally, the concept of the CSN emerged at the beginning of the 20th century. Although some authors claim that this concept derives from the relationship between psychotherapy and mental health, others directly attribute its origin to Hildegard Peplau's work (Lynch et al., 2008). By the 90's, the CSN concept had evolved, placing more emphasis on meeting standards, developing the profession, preventing burnout and promoting safe practice (Lynch et al., 2008; O'Shea et al., 2019).

The CSN has become an important strategy for promoting positive working environments, quality health care outcomes and professional development, becoming an essential component to health organizations and in students' academic education (Dahlke et al., 2016). Its implementation was facilitated with the development of the Proctor model. This model is dynamic and conceives the CSN in three functions that can be implemented simultaneously or separately: formative, normative and restorative. The formative function promotes knowledge by developing capacities and competencies; the normative promotes quality nursing care through compliance with standards, projects and protocols; and the restorative or supportive function aims to support and provide skills for managing emotions to the person under supervision (Proctor, 1991).

The CSN has been investigated and implemented in students and nurses for decades (Cutcliffe et al., 2018; Pollock et al., 2017). In spite of the benefits described in the literature, the CSN it is rarely by nurses in their clinical practice. Therefore, valuing CSN in research, education, clinical practice and managements of health organizations becomes increasingly important (Markey et al., 2020).

During the past few years, the care provided by caregivers has been a concern for nurses and consequently for CSN (Teixeira et al., 2016). The term caregiver refers to someone who has a significant personal relationship with a person being cared for, such as family member, friend or neighbor (Family Caregiver Alliance [FCA], 2014).

Several countries prioritize caregivers in their national health services, as this role demands an enormous sense of responsibility, increasing the physical, psychological and financial burden. However, most caregivers do not possess the necessary knowledge and skills to provide care adequately. As a result, the quality of care provided is affected. Furthermore, the high rates of hospital readmissions demonstrate that poor formal and informal support networks interfere with the quality of care, people's lives, and the health services of several countries. By providing caregivers with the appropriate support, healthcare costs are reduced, healthcare quality and efficiency are improved, and the caregivers' well-being is enhanced (Torres et al., 2020).

However, knowledge on how nurses supervise the caregivers is still scarce. Therefore, this lack of knowledge is the reason why the applicability and potential effectiveness of the care provided by caregivers is still unknown. For this reason, mapping strategies related to clinical nursing supervision is highly relevant.

A scoping review is imperative to explore the extent of the existing literature, map and organize the evidence for future investigations (Peters et al., 2020). A preliminary search on MEDLINE, Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted, and no current or underway systematic reviews or scoping reviews on the topic were identified. In addition, considering that the evidence found on this topic is scarce, unclear and dispersed, it is pertinent and appropriate to carry out a scoping review to map the supervisory strategies used by nurses to promote the quality of care provided by caregiver.

This scoping review intends to answer the following questions:

1. What are the supervisory strategies used by nurses to promote the quality of care provided by caregiver?
2. What are the characteristics (duration and frequency) of these strategies?
3. In what contexts are supervisory strategies implemented to promote the quality of care provided by caregiver?

1. METHODS

The scoping review will be conducted in accordance with the JBI methodology for scoping reviews (Peters et al., 2020) and written following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Reviews Extension for Scoping Reviews (PRISMA-ScR) checklist (McGowan et al., 2020). The current protocol followed the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) (Moher et al., 2015) and is registered in the Open Science Framework (https://osf.io/pvnwc/).

The Participants (P) under analysis in this scoping review are nurses, regardless of academic qualifications and professional practice time, who have implemented clinical supervision to promote quality of care provided by caregiver.

In this scoping review, the Concept (C) under analysis is the clinical supervisory strategies used by nurses in the community to enhance the quality of care provided by caregivers. These include informational and educational programs (Kin et al., 2021; Mazanec et al., 2019; Rico-Blázquez et al., 2021; Vieira et al., 2021); instructing on procedures and identifying community support networks (Vieira et al., 2021); training procedures, skills and communication techniques (Mazanec et al., 2019; Vieira et al., 2021); and providing emotional support (Rico-Blázquez et al., 2021).

The Context (C) under analysis in this scoping review is the community, regardless of the type of country and culture. All studies that address the clinical supervision of nurse in the community to promote quality of care provided by caregiver will be analyzed. In this review, the community refers to any context except the hospital environment, such as the residence of the people, health centers, day care centers, nursing homes and caring homes.

This scoping review will consider both experimental and quasi-experimental study designs including randomized controlled trials, non-randomized controlled trials, before and after studies and interrupted time-series studies. Analytical observational studies including prospective and retrospective cohort studies, case-control studies and analytical cross-sectional studies will be considered for inclusion. This review will also consider descriptive observational study designs including case series, individual case reports and descriptive cross-sectional studies for inclusion.

Qualitative studies will also be considered that focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, qualitative description, action research and feminist research.

Systematic reviews that meet the inclusion criteria will also be considered, depending on the research question.

Text and opinion papers will also be considered for inclusion in this scoping review.

Studies published in English, Portuguese and Spanish since 1993 will be included in this review. The translation processes will be rigorous and the full responsibility of the authors. The temporal limit selected is due to the year (1993) in which clinical supervision was defined more clearly and objectively, so the authors consider that from this year there was a change in the concept, investigation and implementation of clinical supervision (Department of Health [DOH], 1993). It should be noted that there are no geographical or cultural limitations in the inclusion of studies as it is intended to understand the clinical supervision of nurse in the community to promote quality of care provide by caregiver in different contexts.

The search strategy will aim to locate both published and unpublished studies. An initial limited search of MEDLINE (PubMed) and CINAHL (EBSCOhost) was undertaken to identify literature on the topic. The text words contained in the titles and abstracts of relevant articles and their index terms were used to develop a full search strategy for the PubMed database (Table 1). The search strategy, including all identified keywords and index terms, will be adapted for each included database and/or information source. The reference list of all included sources of evidence will be screened for additional studies.

Table 1 – Search strategy: MEDLINE (PubMed) on January 28th 2022.

Search	Query	Records retrieved
#1	"Home Nursing"[MeSH Terms] OR "Home Care Services"[MeSH Terms]	49,637
#2	"nursing, supervisory"[MeSH Terms] OR "Nursing Assessment"[MeSH Terms] OR "quality indicators, health care"[MeSH Terms] OR "quality assurance, health care"[MeSH Terms:noexp] OR "Patient Education Handout"[Publication Type] OR "Behavior Observation Techniques"[MeSH Terms]	124,550
#3	"nurses, community health"[MeSH Terms] OR "practice patterns, nurses"[MeSH Terms] OR "Nurses"[MeSH Terms]	96,691
#4	"nurs*"[Title/Abstract]	498,650
#5	"support*"[Title/Abstract] OR "technique*"[Title/Abstract] OR "supervis*"[Title/Abstract] OR "observation"[Title/Abstract] OR "educational intervention"[Title/Abstract] OR "educational interventions"[Title/Abstract] OR "sanitary supervision"[Title/Abstract]	3,642,479
#6	"communit*"[Title/Abstract] OR "domicile*"[Title/Abstract] OR "residential care home"[Title/Abstract] OR "home help"[Title/Abstract] OR "home care"[Title/Abstract] OR "home nursing"[Title/Abstract]	677,961
#7	#1 OR #6	710,440
#8	#2 OR #5	3,750,337
#9	#3 OR #4	533,363
#10	#7 AND #8 AND #9	16,502
#11	#10 AND ((1993/1/1:2022/1/28[pdat]) AND (english[Filter] OR portuguese[Filter] OR spanish[Filter]))	14,284

The databases to be searched include MEDLINE (PubMed), CINAHL (EBSCOhost), PsycINFO (EBSCOhost), Nursing & Allied Health Collection (EBSCOhost), Cochrane Central Register of Controlled Trials (EBSCOhost), MedicLatina (EBSCOhost), Web of Science (ESEP), Scopus (ESEP) and LILACS (Biblioteca Virtual em Saúde). Sources of unpublished studies include WorldWideScience, DART-Europe, Open Access Theses and Dissertations and the Repositório Científico de Acesso Aberto em Portugal (RCAAP).

Following the search, all identified citations will be collated and uploaded into Rayyan – Intelligent Systematic Review (Ouzzani et al., 2016) and duplicates removed. Following a pilot test, titles and abstracts will then be screened by two independent reviewers (MC, IE) for assessment against the inclusion criteria for the review. Potentially relevant sources will be retrieved in full. The full text of selected citations will be assessed in detail against the inclusion criteria by two independent reviewers (MC, IE). Reasons for exclusion will be recorded and reported in the scoping review. Any disagreements that arise between the reviewers at each stage of the selection process will be resolved through discussion or with a third reviewer (MM).

The search results and the study inclusion process will be reported in full in the final scoping review and presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping review (PRISMA-ScR) flow diagram (Peters et al., 2020).

Data will be extracted from papers included in the scoping review by two independent reviewers (MC, IE) using a data extraction tool developed by the reviewers (Table 2). The data extracted will include specific details about the participants, concept, context, study methods and key findings relevant to the review questions. During the process of extracting data from each included source of evidence, this tool will be modified and revised as necessary. Modifications will be detailed in the scoping review. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer (MM). If appropriate, authors of papers will be contacted to request missing or additional data, where required.

Table 2 – Data extraction instrument.

Data extraction date
Reviewer
Article title
Author(s)
Year and place of publication
Study objectives
Study methods
Participants
Supervisory strategies implemented and their characteristics
Study context
Other important results
Main conclusions
Comments

The results will be presented in a tabular form, organized by publication decades of the studies included in the review (Table 3).

Table 3 – Data analysis and presentation.

Decade	**1993-1999**	**2000-2009**	**2010-2019**	**2020-2022**
Results				

For each question formulated in this scoping review, tables will be developed with all the data obtained and the level of evidence of the selected studies will be represented graphically.

A narrative summary with all the results will also be developed, and will accompany the tabulated and charted results, in order to answer and relate the results to the objectives and questions of this scoping review.

2. RESULTS

This scoping review will include studies on CS implemented by nurses in a community context to promote the quality of care provided by the caregiver. From the previous bibliographic research, some supervisory strategies are verified, namely, informational and educational programs (Kin et al., 2021; Mazanec et al., 2019; Rico-Blázquez et al., 2021; Vieira et al., 2021); instructing on procedures and identifying community support networks (Vieira et al., 2021); training procedures, skills and communication techniques (Mazanec et al., 2019; Vieira et al., 2021); and providing emotional support (Rico-Blázquez et al., 2021).

Given the high rates of hospital readmissions and the lack of necessary and adequate knowledge and skills in the caregiver to provide care, CSN becomes essential (Torres et al., 2020). Nurses, through the implementation of several supervisory strategies, can enable the caregiver to provide higher quality care. Therefore, the health costs associated with hospital readmission rates will be reduced, the quality of care and the development health services are promoted (Mazanec et al., 2019; Torres et al., 2020).

The identification and mapping of existing knowledge about the supervision strategies used by the nurse in the community will contribute to improve the quality of care provided by the caregiver, respond to the most diverse problems that health services face daily and challenge the organizations and health policies of the several countries to value the role of the nurse with the caregiver (Markey et al., 2020; Torres et al., 2020).

CONCLUSION

Nurses are the reference health professionals to implement CS and to promote the quality of care provided by caregivers, contributing to people's health gains and to the improvement of health services (Teixeira et al., 2016; Torres et al., 2020). The supervisory strategies implemented by nurses in the community are decisive for the quality of care provided by the caregiver and for obtaining health gains (Kin et al., 2021; Mazanec et al., 2019; Rico-Blázquez et al., 2021; Vieira et al., 2021).

This scoping review is extremely relevant for nursing research, teaching and clinical practice because it will increase knowledge about CSN, namely, it increases knowledge about supervisory strategies implemented by nurses in the community to promote the quality of care provided by caregivers and their characteristics. In turn, these results will make it possible to respond to the daily challenges of health organizations and health policies in different countries, such as hospital readmission rates, the quality of care and the development health services (Markey et al., 2020; Mazanec et al., 2019; Torres et al., 2020).

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CIÊNCIAS DA VIDA E DA SAÚDE
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QUALIDADE DE VIDA RELACIONADA COM A SAÚDE ORAL EM ESTUDANTES DO ENSINO SUPERIOR
QUALITY OF LIFE RELATED TO ORAL HEALTH IN HIGHER EDUCATION STUDENTS
CALIDAD DE VIDA RELACIONADA CON LA SALUD BUCODENTAL EN ESTUDIANTES DE EDUCACIÓN SUPERIOR

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RESUMO

Introdução: A qualidade de vida relacionada com a saúde oral é multidimensional e traduz o impacto da saúde oral no bem-estar funcional, social e psicológico. Os comportamentos de saúde oral têm tradução ao longo do ciclo vital e podem afetar a qualidade de vida.

Objetivo: Avaliar a qualidade de vida relacionada com a saúde oral em estudantes do ensino superior; inferir da relação entre as variáveis sociodemográficas e comportamentais e o nível de qualidade de vida relacionada com a saúde oral autoreferido.

Métodos: Estudo transversal, quantitativo, descritivo e correlacional em 430 estudantes do ensino superior da região norte de Portugal. Predomínio de indivíduos do sexo feminino (n=342; 79.5%) e com idades entre os 18 e os 22 anos (n=297; 69.1%). Aplicado um questionário *online* constituído por variáveis sociodemográficas e comportamentais e pela versão breve do *Oral Health Impact Profile* (OHIP-14). Utilizaram-se testes não paramétricos com intervalo de confiança de 95%.

Resultados: A maioria dos estudantes escova os dentes e a boca duas ou mais vezes por dia (n=367; 85.4%) e tem patologia da cavidade oral (n=306; 71.1%). 50.2% (n=216) têm zonas edêntulas e 42.3% (n=188) frequentam consultas com profissionais de SO apenas quando é necessário. O score médio do OHIP-14 foi de 6.142 (±9.137). Há associação estatisticamente significativa entre as variáveis comportamentais e o score total do OHIP-14.

Conclusão: A pontuação média do OHIP-14 traduz ausência de impacto da saúde oral na qualidade de vida da amostra. Os comportamentos de saúde oral influenciam a qualidade de vida relacionada com a saúde oral.

Palavras-chave: qualidade de vida; saúde bucal; autorrelato; educação superior; estudantes

ABSTRACT

Introduction: Oral health-related quality of life is multidimensional and reflects the impact of oral health (OH) on functional, social and psychological well-being. Oral health behaviors translate throughout the life cycle and can affect the quality of life.

Objective: To assess oral health-related quality of life in higher education students; to infer the relationship between sociodemographic and behavioral variables and the level of self-reported oral health-related quality of life.

Methods: Cross-sectional, quantitative, descriptive and correlational study in 430 higher education students from the northen region of portugal. Predominance of female individuals (n=342; 79.5%) aged between 18 and 22 years (n=297; 69.1%). An online survey consisting of sociodemographic and behavioral variables and the short version of the Oral Health Impact Profile (OHIP-14) was applied. Nonparametric tests with a 95% confidence interval were used.

Results: Most students brush their teeth and mouth two or more times a day (n=367; 85.4%) and have oral cavity pathology (n=306; 71.1%). 50.2% (n=216) have edentulous areas and 42.3% (n=188) attend consultations with OH professionals only when absolutely necessary. The average OHIP-14 score was 6,142 (±9,137). There is a statistically significant association between behavioral variables and the total OHIP-14 score.

Conclusion: The average OHIP-14 score reflects the absence of an impact of oral health on the sample's quality of life. Oral health behaviors influence oral health-related quality of life.

Keywords: quality of life; oral health; self-report; education, higher; students

RESUMEN

Introducción: La calidad de vida relacionada con la salud bucodental es multidimensional y traduce el impacto de la salud bucodental en el bienestar funcional, social y psicológico. Los comportamientos del SO tienen traducción a lo largo del ciclo vital y pueden afectar a la calidad de vida.

Objetivo: Evaluar la calidad de vida relacionada con la salud bucodental en estudiantes de educación superior; inferir la relación entre las variables sociodemográficas y de comportamiento y el nivel de calidad de vida relacionada con la salud bucodental autodeclarado.

Métodos: Estudio transversal, cuantitativo, descriptivo y correlacional en 430 estudiantes de educación superior de la région norte de Portugal. Predominan las mujeres (n=342; 79,5%) y las edades comprendidas entre los 18 y los 22 años (n=297; 69,1%). Se aplicó un cuestionario online que consistía en variables sociodemográficas y de comportamiento y la versión corta del Perfil de Impacto en la Salud Oral (OHIP-14). Se utilizaron pruebas no paramétricas con un intervalo de confianza del 95%.

Resultados: La mayoría de los estudiantes se cepillan los dientes y la boca dos o más veces al día (n=367; 85,4%) y tienen patología de la cavidad oral (n=306; 71,1%). El 50,2% (n=216) tiene zonas edéntulas y el 42,3% (n=188) acude a las consultas de los profesionales de la salud bucodentale cuando es necesario. La puntuación media del OHIP-14 fue de 6,142 (±9,137). Existe una asociación estadísticamente significativa entre las variables de comportamiento y la puntuación total del OHIP-14.

Conclusión: la puntuación media del OHIP-14 no refleja ningún impacto de la salud bucodentale en la calidad de vida de la muestra. Los comportamientos de la salud bucodentale influyen en la calidad de vida relacionada con la salud bucodental.

Palabras Clave: calidad de vida; salud bucal; autoinforme; educación superior; estudantes

THEORETICAL FRAMEWORK

As an indicator of health in general, OH is representative of the individual's quality of life, and the interest in its study has taken on greater expression over the last few years. Conceptualized by the World Health Organization (WHO, 2022) as the absence of orofacial pain, oral pathology and disorders that limit the physical functions of the oral cavity and psychosocial well-being, a high level of OH includes, but is not limited to physiological functions (Glick et al., 2012). In this regard, Lee et al. (2017) highlight the need to base the measurement of OH of populations on the status and condition of OH but also on psychosocial function, recognizing the limitation of morbidity and mortality indicators and the need to value broader social determinants that respond to the growing interest of individuals in health literacy and quality of life.

According to the Global Burden of Disease Study (GDB 2016 Diseases and Injury and Prevalence, 2017), it is estimated that oral pathologies are present in half of the world population, an indicator that places them at the forefront of public health problems (Sousa, 2016). The WHO (2022) predicts that, in Europe, severe periodontal disease affects 5 to 20% of adults between 35 and 44 years of age, and, according to the International Dental Federation (IDF, 2015), in 2010, 3.9 billion individuals had oral pathology. With a prevalence of 40% worldwide (IDF, 2015), dental caries, although preventable, have an impact on food, sleep and rest, growth and school and work absenteeism, reflecting health care and the hygienic-sanitary conditions of the populations. Currently, in Portugal, diseases of the oral cavity are considered a national public health problem, as they have significance in the general health level of individuals and translate into the quality of life (Direção-Geral da Saúde, 2019, 2021).

Young adults, whose chronological age, by definition, is between 18 and 25 years old, experience a period marked by biopsychosocial development, where experiences with peers and the socio-family context lead to the adoption of lifestyles and behaviors that can be protectors or hinderers of the best level of health in general (Committee on Improving the Health, Safety, and Well-Being of Young Adults, Board on Children, Youth, and Families, Institute of Medicine, & National Research Council, 2015). This stage of the life cycle often represents the abandonment of the family nucleus and entry into academic life, which is sometimes characterized by behaviors that hinder a high level of OH, such as the use of tobacco, alcohol intake, addiction to drugs and other substances, a diet rich in sugars and poor oral hygiene (Dias et al., 2020; Kojima et al., 2014). These behaviors are reflected throughout the life cycle and predict the incidence of oral pathology in adult life, so the implementation of programs aimed at this population setting, which integrate awareness of the urgency of oral hygiene care and surveillance of the condition of OH, should be a priority in the definition of health policies. Corroborating this need, Drachev, Brenn and Trovik (2018) state that, although oral disease is prevalent in the elderly population, young adults and adults have worse oral hygiene and, inherently, will have a greater impact on quality of life. Thus, it is urgent to measure the OHRQoL self-perception (Choi, et al., 2015).

The literature review reiterates the weight of the impact of OH status on the quality of life, so it is pertinent to include this variable in studies that concern the assessment of health-related quality of life (Ramos & Soares, 2021). Currently, OHRQoL is understood as a multidimensional concept that reflects the comfort of individuals during eating, sleeping and social relationships and which has an impact on self-esteem and self-image, with higher education students with better self-perception of OH and better OH behaviors better self-report OHRQoL (Yamane-Takeuchi, et al., 2016).

1. METHODS

A possible relationship between quality of life and OH emerges from the literature review, so, given the defined objectives, an empirical, descriptive and correlational study was designed, in a transversal plan, with a quantitative approach.

1.1 Sample

In the academic year 2021/2022, 9082 students attend higher education in the district of Bragança, Portugal, of which 430 participated in the study, mostly female (n=342; 70.5%), aged between 18 and 22 years old (n=297, 69.1%), of Portuguese nationality (n=298; 69.3%) and attending a course taught at the Escola Superior de Saúde (n=326; 75.8%). A convenience sample was constituted, defining as inclusion criteria the written comprehension of the Portuguese language and enrollment in higher education institutions of this district.

1.2 Data collection instruments

Data collection was carried out by answering an online questionnaire prepared on the Google Forms® platform and took place between August and December 2021. For the dissemination of the study, the collaboration of class representatives and teachers of higher education institutions was requested, and the access link to the questionnaire was sent via email.

The data collection instrument consists of a sociodemographic questionnaire designed for this purpose, which integrates sociodemographic and behavioral variables, and the short version of the OHIP-14 translated and validated for the Portuguese population by Afonso et al. (2017). In the sociodemographic characterization, the variables age, sex and nationality were assessed, and, for the behavioral characterization, the students answered questions about the habits of intake of sugary foods, frequency of OH appointments, presence of edentulism, use of tooth replacement and smoking habits. A question was also asked about the self-perception of the OHRQoL level. The OHIP-14 is the most used instrument to assess OHRQoL self-perception and enables the collection of information on the severity, prevalence and extent of the impact of OH on the quality of life. It comprises 14 items that are grouped together to respond to the dimensions Functional limitation (items 1 and 2), Physical pain (items 3 and 4), Psychological discomfort (items 5 and 6), Physical disability (items 7 and 8), Psychological disability (items 9 and 10), Social Disability (items 11 and 12) and Disadvantage (items 13 and 14). In response to each item, the participant is positioned on a Likert scale scored between 0 and 4 (0=Never; 1=Rarely; 2=Rarely; 3=Sometimes; 4=Almost always) that reflects the frequency with which he experienced the utterance in the previous 12 months. In the present study, we chose to interpret the OHIP-14 through the addition method for all items and dimensions, with the total score varying between 0 and 56 points and the score per dimension between 0 and 8 points. The higher the total score, the greater the impact of OH on the individual's quality of life, with a score equal to or less than 14 points indicating no impact of OH on quality of life (Isiekwe, Onigbogi, Olatosi, & Sofola, 2014). The prevalence of impacts was also calculated by counting the number of items in which the students positioned themselves in the options A few times, Sometimes or Almost always, which allowed the dichotomization of the variable OHRQoL in With impact and Without impact.

The Portuguese version of the OHIP-14 is an instrument with good construct validity, high fidelity and sensitivity to sociodemographic, clinical and self-perception characteristics, it has psychometric properties similar to the original version and has a global internal consistency for the seven dimensions with Cronbach's Alpha. =0.95 (Afonso et al., 2017).

1.3 Statistical analysis

The collected data were processed in the IBM Statistica Package for Social Sciences® software, using descriptive and inferential statistics for their analysis.

The descriptive treatment of the data is presented as mean and standard deviation for continuous variables and as median with interquartile range for categorical variables. For inferential statistics, was chosen to use non-parametric tests, namely the Mann Whitney U Test, the Spearman Correlation and the Chi-Square Test. A confidence level of 95% ($p<0.05$) was defined, and the internal consistency of the OHIP-14 for the sample under study was evaluated by calculating Cronbach's Alpha.

1.4 Ethical procedures

Participation in the study complied with all the precepts recommended in the Declaration of Helsinki, the Oviedo Convention and the General Data Protection Regulation. The answer to the data collection instrument was preceded by the reading of the free, enlightened and informed consent, guaranteeing the confidentiality and anonymity of the data collected, and the identification of the respondent was never allowed during the response to the data collection instrument. A favorable decision was obtained from the Ethics Committee of the Polytechnic Institute of Bragança, according to Opinion Nr. 60/2021.

2. RESULTS

A total of 430 students participated in the study, mostly female (n=342; 79.5%), of Portuguese nationality (n=298; 69.3%) and aged between 18 and 22 years (n=297; 69.1%). The academic characterization of the participants showed that, predominantly, they attend a degree course (n=420; 97.7%) and the Higher Health School (n=326; 75.8%), with 38.4% (n=165) attending the 1st year and only 6.5% (n=28) the 4th year.

In the characterization of the oral condition of the sample, it was found that 71.1% of students (n=306) have a history of oral pathology and 50.2% (n=216) have edentulous areas, of which only 8.3% (n=18) use tooth replacement mechanisms. With regard to behavioral variables (Table 1), all students (n=430; 100.0%) reported brushing their teeth and mouth, with this habit being performed twice or more times a day by 85.4% of the sample (n=367). However, 14.0% (n=60) do not attend appointments with OH professionals. Of those who do it regularly (n=188; 43.7%), the majority attended an appointment less than a year ago (n=275; 64.0%), with oral health surveillance (n=245; 56.9%) the most important. main reason mentioned. When asked about the reason for not attending appointments with OH professionals, the main reasons mentioned were the associated cost (n=119; 27.7%) and fear (n=54; 12.6%).

In the characterization of OH determinants, it was found that most students do not smoke (n=320; 74.4%) and that 48.6% (n=209) occasionally ingest sugary drinks or foods, although 45.1% (n= 194) recognize the increasing intake of these foods during the study period.

Table 1 - Sample distribution according to sex and behavioral variables

		Sex				Total	
		Female		Male			
		n	%	n	%	n	%
Habit of brushing teeth and mouth	Yes	342	79.5	88	20.5	430	100.0
	No	-	-	-	-	-	-
	Total	342	79.5	88	20.5	430	100.0
Frequency of brushing teeth and mouth	1 once a day	35	8.1	28	6.5	63	14.6
	2 twice or more a day	307	71.4	60	14.0	367	85.4
	Total	342	79.5	88	20.5	430	100.0
Oral pathology	Yes	247	57.4	59	13.7	306	71.1
	No	95	22.2	29	6.7	124	28.9
	Total	342	79.5	88	20.5	430	100.0
Frequency of OH appointments	*Yes, regularly*	158	36.7	30	7.0	188	43.7
	Yes, whenever necessary	150	34.9	32	7.4	182	42.3
	No	34	8.0	26	6.0	60	14.0
	Total	342	79.5	88	20.5	430	100.0
Smoking habits	*Yes, nowadays*	42	9.8	34	7.9	76	17.7
	Yes, previously	26	6.0	8	1.9	34	7.9
	No	274	63.7	46	10.7	320	74.4
	Total	342	79.5	88	20.5	430	100.0
Drinking sugary drinks or foods	*Daily*	50	11.6	17	4.0	67	15.6
	Most days	112	26.0	28	6.5	140	32.5
	Occasionally	171	39.8	38	8.8	209	48.6
	Never	9	2.1	5	1.2	14	3.3
	Total	342	79.5	88	20.5	430	100.0
Increasing intake of sugary drinks or foods during the study	*Yes*	151	35.1	43	10.0	194	45.1
	No	191	44.4	45	10.5	236	54.9
	Total	342	79.5	88	20.5	430	100.0

From the correlational analysis of the sociodemographic variables with the behavioral variables, it was found that the presence of oral pathology is associated with statistical significance with the variables Frequency of intake of sugary drinks or foods (p=0.007) and Increase in intake of these foods during the period of study (p=0.019), with a positive linear relationship between these variables. It was found that there is a statistically significant association between the presence of edentulous areas and the frequency of appointments with OH professionals (p=0.008), and students with edentulism tend to be those who least have this behavior of seeking OH. The age of the respondents is a variable that is statistically associated with the variables Frequency of consultations with OH professionals (p=0.015), Use of dental prosthesis (p=0.000), Presence of edentulous areas (p=0.000) and Tobacco use (p=0.000), having a negative linear relationship with all, except for the frequency of consultations with OH professionals.

Although most of the students self-rate their OH as good (n=226; 52.6%) or very good (n=67; 15.6%), 67.4% (n=290) they also consider that it affects very or moderately their quality of life. The assessment of the OHRQoL self-perception was achieved through the response to the OHIP-14 (Table 2), obtaining a total mean score of 6,142 (±9,137), with scores ranging between 0 and 56 points, reflecting the absence of impact of the OHRQoL. in the quality of life of students. On average, the most scored dimensions were Physical Pain (χ=1,423±1,648) and Psychological Disability (χ=1,119±1,780) and the least scored were Social Disability (χ=0,551±1,378) and Disadvantage (χ=0,563 ±1,379). These results reflect the item-by-item score, as the most rated items were the sensation of pain (χ=0.719±0.897) and the feeling of discomfort during eating (χ=0.705±0.953) and the lowest punctuated the perception of inability to perform activities (χ=0.233±0.698) and the feeling of difficulty in performing usual tasks (χ=0.251±0.698). The scale revealed to have a very good internal consistency for the sample under study, with Cronbach's Alpha value for the OHIP-14 being 0.881, with a range for dimensions from 0.580 to 0.915.

Table 2 - OHRQoL self-perception

OHIP-14	Score				Impact on QoL				Cronbach' Alpha
	Average (dp)	Min.	Max.	Variance	With impact		Without impact		
					n	%	n	%	
Dimension 1 *Functional Limitation*	0.705 (±1.500)	0	8	2.251	25	5.8	405	94.2	0.705
Dimension 2 *Physical pain*	1.423 (±1.648)	0	8	2.716	49	11.4	381	88.6	0.892
Dimension 3 *Psychological Disability*	1.086 (±1.726)	0	8	2.979	44	10.2	386	89.8	0.899
Dimension 4 *Physical Disability*	0.695 (±1.399)	0	8	1.956	23	5.3	407	94.7	0.915
Dimension 5 *Psychological Disability*	1.119 (±1.780)	0	8	3.168	33	7.7	397	92.3	0.589
Dimension 6 *Social Disability*	0.551 (±1.378)	0	8	1.898	19	4.4	411	95.6	0.822
Dimension 7 *Disadvantage*	0.563 (±1.379)	0	8	1.902	22	5.1	408	94.9	0.580
OHIP-14 Total	6.142 (±9.137)	0	56	83.488	57	13.3	373	86.7	0.881

From the correlational study between sociodemographic variables and OHRQoL self-perception, a statistically significant relationship between the age group of students and the total OHIP-14 score (p=0.000) is evidenced, assuming a positive linear relationship between these variables (Spearman correlation with range for dimensions between 0.151 and 0.242). Likewise, the academic year and the educational institution have a statistically significant association with the level of self-reported OHRQoL (p=0.001 and p=0.000, respectively), although there are no statistically significant differences between the academic year and the average of the total score of the OHIP-14 (p greater than 0.05 for the t-Test).

By analyzing the correlation of the OHRQoL level with the behavioral variables, it is inferred that there is statistical significance between the total OHIP-14 score and the number of teeth and mouth brushing (p=0.000), the presence of oral pathology (p=0.000), frequency of appointments with OH professionals (p=0.001), use of dental prosthesis (p=0.000), tobacco use (p=0.003), consumption of sugary drinks or foods (p= 0.040) and increased intake of these products during the study period (p=0.000). With the exception of the variable Frequency of appointments with OH professionals, all the others present a negative linear relationship with the total score of the OHIP-14 (Spearman correlation with intervals between -0.327 and -0.099), so they constitute behaviors that facilitate worse OHRQoL.

3. DISCUSSION

The concept of OHRQoL is multidimensional, so when measuring it, it is essential to integrate factors that go beyond physical discomfort and dysfunction of the oral cavity and that include emotions and social functions associated with OH. Currently, OH indicators reflect a public health concern, meaning loss of years of healthy life and increasing health costs due to the prevalence of oral pathology in communities (Direção-Geral da Saúde, 2021; FDI, 2015; Glick et al., 2012). Although sensitive to determinants such as OH-seeking behaviors, socioeconomic status and age, OH level determines quality of life, and this impact is consensual in the literature review.

In higher education students, the OH status is relevant and has an impact throughout life, and there is a set of conditions arising from the challenges inherent to this stage of the life cycle that present themselves as determinants of OH. At the same time, it is considered that the aesthetic and functional factors resulting from the individual's oral condition affect social life, food, daily performance and well-being, so it is relevant to understand the self-perception of OHRQoL.

In the study carried out, the mean OHIP-14 score was 6,142 (±9,137), revealing the absence of an impact of OH on the quality of life. This evidence is in line with previous studies that used higher education students as units of analysis (Dias et al., 2020; Drachev, Brenn & Trovik, 2018; Isiekwe et al. 2014; Luz, 2020; Yamane.Takeuchi et al. ., 2016). However, this result is inconsistent with the oral condition found in the sample and with the national OH indicators that expose the prevalence of oral pathology (Ordem dos Médicos Dentistas, 2021), which reveals the apparent undervaluation by higher education students of the impact of OH on the quality of life. Uzarevic and Bulj (2021), in a study carried out in Croatia, aimed at an average score for the OHIP-14 slightly higher than that of the sample under study, and this difference may depend on the sociodemographic characteristics of the participants as far as they self-define health.

Physical pain, psychological disability and psychological discomfort were the most scored dimensions of the OHIP-14, evidencing the impact of higher education students' OH on social functions. Gonzales-Sullcahuaman et al. (2013) and Yamane-Takeuchi et al. (2016), in studies carried out in similar populations, showed that physical pain and psychological discomfort were highly scored dimensions, associating the results obtained with the prevalence of oral disease and the impact that the OH status has on the performance of daily activities and on the relationship with the other.

OH-seeking behaviors are variables that influence the OH level of populations and result from the ease of access to care and the population's level of health literacy. In this sample, students with a history of oral pathology and edentulous areas prevail. This result does not exceed expectations, insofar as it is about participants aged, mostly, between 18 and 22 years old and with skills that allow them to search for knowledge, determinants that present themselves as facilitators of the search for information and the adoption of protective OH behaviors. Although oral hygiene habits are adequate, which corroborate what was evidenced by Fortes et al. (2016) and by Sousa (2016) and which meet the recommendations of national directives (Direção-Geral da Saúde, 2019; 2021), the correlation of behavioral variables with the total OHIP-14 score illustrates the weight of neglect of behaviors such as monitoring the OH condition, eating foods high in sugar or smoking addiction.

Smoking and eating habits are modifiable determinants of OH. In the present study, most respondents do not smoke, but consume sugary drinks or foods, and, similarly to the study by Luz (2020), students who frequently consume these foods self-reported a greater impact of OH on the quality of life. According to the FDI (2015), excessive consumption of sugary rich food promotes the appearance of dental caries and periodontal disease, health conditions with an impact on the physical, functional and social functions of the individual and with significance in comfort, self-image, self-esteem and well-being. Given the evolution of national OH policies and the sociodemographic characteristics of the sample, a lower impact of the determinants of OH on the OHRQoL was expected, a result that reiterates the relevance of studying this variable for the definition of strategies aimed at the needs felt by the individual.

Regarding the demand for OH care, it was found that most students do not attend appointments with OH professionals or only do so when necessary, with the cost associated with care and fear being the main reasons for not seeking them. These results mirror what has been demonstrated by the Portuguese Dental Association (2021) and by Monteiro (2018) and show the urgency of expanding measures that promote the equity in access to OH care and the effective integration of this care into the National Health Service.

CONCLUSION

The average OHIP-14 score reflects the lack of impact of OH on the quality of life of higher education students who participated in the study. The most scored dimensions were Physical Pain and Psychological Disability, inferring that OH is multidimensional and that it determines conditions of discomfort, physical dysfunction, psychological suffering and decreasing well-being. This evidence reiterates the relevance of integrating the OHRQoL assessment in the global assessment of OH status, as this is an outcome variable that offers contributions to the definition of strategies centered on the individual and promoting OH.

It was concluded that behaviors in OH have impact in OHRQoL, and the negligence of seeking OH care has a negative impact on the quality of life of higher education students. From this fact, emerges the need to implement more comprehensive strategies that integrate disadvantaged population settings with regard to OH. In Portugal, despite the evolution of measures promoting equity in access to health care, there is still a gap between the needs in OH and the provision of care, and the costs associated with these are effectively an obstacle in the promotion of OH. Thus, the effective integration of OH care into the National Health Service and the measurement of indicators that go beyond morbidity and mortality are urgent.

The sample size is recognized as a limitation of the study, as it does not allow the generalization of data to the population of higher education students, and the limitation to a geographic area, so it is suggested to carry out more comprehensive studies that include variables such as the socioeconomic status, the OH care network and the OH promotion resources and strategies made available by educational institutions.

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QUALIDADE DE VIDA RELACIONADA COM A SAÚDE ORAL EM ESTUDANTES DO ENSINO SUPERIOR
QUALITY OF LIFE RELATED TO ORAL HEALTH IN HIGHER EDUCATION STUDENTS
CALIDAD DE VIDA RELACIONADA CON LA SALUD BUCODENTAL EN ESTUDIANTES DE EDUCACIÓN SUPERIOR

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RESUMO

Introdução: A qualidade de vida relacionada com a saúde oral é multidimensional e traduz o impacto da saúde oral no bem-estar funcional, social e psicológico. Os comportamentos de saúde oral têm tradução ao longo do ciclo vital e podem afetar a qualidade de vida.

Objetivo: Avaliar a qualidade de vida relacionada com a saúde oral em estudantes do ensino superior; inferir a relação entre as variáveis sociodemográficas e comportamentais e o nível de qualidade de vida relacionada com a saúde oral autoreferido.

Métodos: Estudo transversal, quantitativo, descritivo e correlacional em 430 estudantes do ensino superior da região norte de Portugal. Predomínio de indivíduos do sexo feminino (n=342; 79.5%) e com idades entre os 18 e os 22 anos (n=297; 69.1%). Aplicado um questionário *online* constituído por variáveis sociodemográficas e comportamentais e pela versão breve do *Oral Health Impact Profile* (OHIP-14). Utilizaram-se testes não paramétricos com intervalo de confiança de 95%.

Resultados: A maioria dos estudantes escova os dentes e a boca duas ou mais vezes por dia (n=367; 85.4%) e tem patologia da cavidade oral (n=306; 71.1%). 50.2% (n=216) têm zonas edêntulas e 42.3% (n=188) frequentam consultas com profissionais de SO apenas quando é necessário. O score médio do OHIP-14 foi de 6.142 (±9.137). Há associação estatisticamente significativa entre as variáveis comportamentais e o score total do OHIP-14.

Conclusão: A pontuação média do OHIP-14 traduz ausência de impacto da saúde oral na qualidade de vida da amostra. Os comportamentos de saúde oral influenciam a qualidade de vida relacionada com a saúde oral.

Palavras-chave: qualidade de vida; saúde bucal; autorrelato; educação superior; estudantes

SUMMARY

Introduction: Oral health-related quality of life is multidimensional and reflects the impact of oral health (OH) on functional, social and psychological well-being. Oral health behaviors translate throughout the life cycle and can affect the quality of life.

Objective: To assess oral health-related quality of life in higher education students; to infer the relationship between sociodemographic and behavioral variables and the level of self-reported oral health-related quality of life.

Methods: Cross-sectional, quantitative, descriptive and correlational study in 430 higher education students from the northen region of portugal. Predominance of female individuals (n=342; 79.5%) aged between 18 and 22 years (n=297; 69.1%). An online survey consisting of sociodemographic and behavioral variables and the short version of the Oral Health Impact Profile (OHIP-14) was applied. Nonparametric tests with a 95% confidence interval were used.

Results: Most students brush their teeth and mouth two or more times a day (n=367; 85.4%) and have oral cavity pathology (n=306; 71.1%). 50.2% (n=216) have edentulous areas and 42.3% (n=188) attend consultations with OH professionals only when absolutely necessary. The average OHIP-14 score was 6,142 (±9,137). There is a statistically significant association between behavioral variables and the total OHIP-14 score.

Conclusion: The average OHIP-14 score reflects the absence of an impact of oral health on the sample's quality of life. Oral health behaviors influence oral health-related quality of life.

Keywords: quality of life; oral health; self-report; education, higher; students

RESUMEN

Introducción: La calidad de vida relacionada con la salud bucodental es multidimensional y traduce el impacto de la salud bucodental en el bienestar funcional, social y psicológico. Los comportamientos del SO tienen traducción a lo largo del ciclo vital y pueden afectar a la calidad de vida.

Objetivo: Evaluar la calidad de vida relacionada con la salud bucodental en estudiantes de educación superior; inferir la relación entre las variables sociodemográficas y de comportamiento y el nivel de calidad de vida relacionada con la salud bucodental autodeclarado.

Métodos: Estudio transversal, cuantitativo, descriptivo y correlacional en 430 estudiantes de educación superior de la région norte de Portugal. Predominan las mujeres (n=342; 79,5%) y las edades comprendidas entre los 18 y los 22 años (n=297; 69,1%). Se aplicó un cuestionario online que consistía en variables sociodemográficas y de comportamiento y la versión corta del Perfil de Impacto en la Salud Oral (OHIP-14). Se utilizaron pruebas no paramétricas con un intervalo de confianza del 95%.

Resultados: La mayoría de los estudiantes se cepillan los dientes y la boca dos o más veces al día (n=367; 85,4%) y tienen patología de la cavidad oral (n=306; 71,1%). El 50,2% (n=216) tiene zonas edéntulas y el 42,3% (n=188) acude a las consultas de los profesionales de la salud bucodentale cuando es necesario. La puntuación media del OHIP-14 fue de 6,142 (±9,137). Existe una asociación estadísticamente significativa entre las variables de comportamiento y la puntuación total del OHIP-14.

Conclusión: la puntuación media del OHIP-14 no refleja ningún impacto de la salud bucodentale en la calidad de vida de la muestra. Los comportamientos de la salud bucodentale influyen en la calidad de vida relacionada con la salud bucodental.

Palabras Clave: calidad de vida; salud bucal; autoinforme; educación superior; estudiantes

INTRODUÇÃO

A saúde oral (SO) integra a saúde em geral, sendo que, atualmente, é reconhecida como componente essencial da qualidade de vida dos indivíduos. Contudo, há condições negativas que persistem, nomeadamente os custos associados aos cuidados de SO, a dificuldade no acesso aos cuidados pelos grupos mais vulneráveis e a negligência de comportamentos protetores da SO (FDI, 2015).

Quando se fala em qualidade de vida relacionada com a saúde oral (QdVRSO), a autoperceção do indivíduo apresenta-se como um determinante a valorizar, na medida em que possibilita a aferição das necessidades sentidas através da mensuração de dados subjetivos que complementam os indicadores de morbimortalidade.

O presente estudo objetiva avaliar a QdVRSO em estudantes do ensino superior e inferir a relação entre as variáveis sociodemográficas e comportamentais e o nível de QdVRSO autoreferido.

1. ENQUADRAMENTO TEÓRICO

Enquanto indicador da saúde em geral, a SO tem representatividade na qualidade de vida do indivíduo, sendo que o interesse pelo seu estudo assumiu maior expressão ao longo dos últimos anos. Conceptualizada pela Organização Mundial da Saúde (OMS, 2022) como a ausência de dor orofacial, de patologia oral e de distúrbios que limitem as funções físicas da cavidade oral e o bem-estar psicossocial, um nível elevado de SO inclui, mas não se limita às funções fisiológicas (Glick et al., 2012). A este propósito, Lee et al. (2017) relevam a necessidade de fundamentar a mensuração da SO das populações no *status* e condição de SO mas também na função psicossocial, reconhecendo a limitação dos indicadores de morbimortalidade e a necessidade de valorizar determinantes sociais mais abrangentes que respondam ao interesse crescente dos indivíduos pela literacia em saúde e pela qualidade de vida.

De acordo com o *Global Burden of Disease Study* (GDB 2016 Diseases and Injury and Prevalence, 2017), estima-se que as patologias orais estejam presentes em metade da população mundial, indicador que as posiciona nos lugares cimeiros dos problemas de saúde pública (Sousa, 2016). A OMS (2022) prevê que, na Europa, a doença periodontal grave afete 5 a 20% dos adultos entre os 35 e os 44 anos, sendo que, segundo a Federação Dentária Internacional (FDI, 2015), em 2010, 3900 milhões de indivíduos tinham patologia oral. Com uma prevalência de 40% a nível mundial (FDI, 2015), a cárie dentária, ainda que passível de prevenção, tem impacto na alimentação, no sono e repouso, no crescimento e no absentismo escolar e laboral, refletindo os cuidados de saúde e as condições higienossanitárias das populações. Atualmente, em Portugal, as doenças da cavidade oral são consideradas um problema de saúde pública nacional, na medida em que têm significado no nível de saúde em geral dos indivíduos e tradução na qualidade de vida (Direção-Geral da Saúde, 2019, 2021).

Os jovens adultos, com idade cronológica, por definição, entre os 18 e os 25 anos, vivenciam um período pautado pelo desenvolvimento biopsicossocial, onde as experiências com os pares e o contexto sociofamiliar vertem na adoção de estilos de vida e de comportamentos que podem ser protetores ou dificultadores do melhor nível de saúde em geral (Committee on Improving the Health, Safety, and Well-Being of Young Adults, Board on Children, Youth, and Families, Institute of Medicine, & National Research Council, 2015). Esta etapa do ciclo vital representa, com frequência, o abandono do núcleo familiar e o ingresso na vida académica, sendo que, por vezes, este é caraterizado por comportamentos dificultadores de um elevado nível de SO, de que são exemplo o uso de tabaco, a ingestão alcoólica, a adição a drogas e outras substâncias, a alimentação rica em açúcares e a precariedade da higiene oral (Dias et al., 2020; Kojima et al., 2014). Estes comportamentos têm reflexo ao longo do ciclo vital e predizem a incidência de patologia oral na vida adulta, pelo que a implementação de programas direcionados a este *setting* populacional, que integrem a sensibilização para a premência dos cuidados de higiene oral e de vigilância da condição de SO, deve ser uma prioridade na definição das políticas de saúde. A corroborar esta necessidade, Drachev, Brenn e Trovik (2018) afirmam que, ainda que a doença oral prevaleça na população idosa, os jovens adultos e adultos têm pior higiene oral e, por inerência, terão maior impacto na qualidade de vida. Desta forma, urge a mensuração da autoperceção da QdVRSO (Choi, et al., 2015).

A revisão da literatura reitera o peso do impacto do *status* de SO na qualidade de vida, pelo que se torna pertinente a inclusão desta variável nos estudos que concernem à avaliação da qualidade de vida relacionada com a saúde (Ramos & Soares, 2021). Atualmente, a QdVRSO é entendida como um conceito multidimensional que reflete o conforto dos indivíduos durante a alimentação, o sono e as relações sociais e que tem impacto na autoestima e na autoimagem, sendo que os estudantes do ensino superior com melhor autoperceção da SO e melhores comportamentos de SO autorrelatam melhor QdVRSO (Yamane-Takeuchi, et al., 2016).

2. MÉTODOS

Da revisão da literatura emerge a possível relação entre a qualidade de vida e a SO, pelo que, atendendo aos objetivos definidos, desenhou-se um estudo empírico, descritivo e correlacional, num plano transversal, com abordagem quantitativa.

2.1 Amostra

No ano letivo 2021/2022 frequentam o ensino superior do distrito de Bragança, Portugal, 9082 estudantes, dos quais 430 participaram no estudo, maioritariamente do sexo feminino (n=342; 70.5%), com idades entre os 18 e os 22 anos (n=297, 69.1%), de nacionalidade portuguesa (n=298; 69.3%) e a frequentar um curso lecionado na Escola Superior de Saúde (n=326; 75.8%). Constituiu-se uma amostra por conveniência, definindo-se como critérios de inclusão a compreensão escrita da língua portuguesa e a inscrição em instituições de ensino superior do referido distrito.

2.2 Instrumentos de recolha de dados

A recolha de dados foi efetuada através da resposta a um questionário online elaborado na plataforma *Google Forms*® e decorreu entre agosto e dezembro de 2021. Para a divulgação do estudo, solicitou-se a colaboração dos representantes de turma e dos docentes das instituições de ensino superior, tendo o link de acesso ao questionário sido enviado através de email.

O instrumento de recolha de dados é constituído por um questionário sociodemográfico elaborado para o efeito, que integra variáveis sociodemográficas e comportamentais, e pela versão breve do OHIP-14 traduzida e validada para a população portuguesa por Afonso et al. (2017). Na caraterização sociodemográfica aferiram-se as variáveis idade, sexo e nacionalidade, sendo que, para a caraterização comportamental, os estudantes responderam a questões sobre os hábitos de ingestão de alimentos açucarados, frequência de consultas de SO, presença de edentulismo, uso de mecanismos de substituição dentária e hábitos tabágicos. Foi ainda efetuada uma questão sobre a autoperceção do nível de QdVRSO.

O OHIP-14 é o instrumento de avaliação da autoperceção da QdVRSO mais utilizado e possibilita a recolha de informação relativa à gravidade, prevalência e extensão do impacto da SO na qualidade de vida. Integra 14 itens que se agrupam para dar resposta às dimensões Limitação funcional (itens 1 e 2), Dor física (itens 3 e 4), Desconforto psicológico (itens 5 e 6), Incapacidade física (itens 7 e 8), Incapacidade psicológica (itens 9 e 10), Incapacidade social (itens 11 e 12) e Desvantagem (itens 13 e 14). Na resposta a cada item, o participante posiciona-se numa escala de *Likert* pontuada entre 0 e 4 (0=Nunca; 1=Raramente; 2=Poucas vezes; 3=Algumas vezes; 4=Quase sempre) que traduz a frequência com que este experienciou o enunciado nos 12 meses anteriores.

No presente estudo, optou-se pela interpretação do OHIP-14 através do método de adição para a totalidade dos itens e para as dimensões, podendo o *score* total variar entre 0 e 56 pontos e o *score* por dimensão entre 0 e 8 pontos. Quanto maior o *score* total, maior é o impacto da SO na qualidade de vida do indivíduo, sendo que um *score* igual ou inferior a 14 pontos indica ausência de impacto da SO na qualidade de vida (Isiekwe, Onigbogi, Olatosi, & Sofola, 2014). Procedeu-se também ao cálculo da prevalência dos impactos através da contagem do número de itens em que os estudantes se posicionaram nas opções Poucas vezes, Algumas vezes ou Quase sempre, o que permitiu a dicotomização da variável QdVRSO em Com impacto e Sem impacto.

A versão portuguesa do OHIP-14 é um instrumento com boa validade de construto, elevada fidelidade e sensibilidade a caraterísticas sociodemográficas, clínicas e de autoperceção, apresenta propriedades psicométricas semelhantes à versão original e tem uma consistência interna global para as sete dimensões com Alfa de Cronbach=0,95 (Afonso et al., 2017).

2.3 Análise estatística

Os dados recolhidos foram processados no *software* IBM *Statistica Package for Social Sciences*®, recorrendo-se à estatística descritiva e inferencial para a análise dos mesmos.

O tratamento descritivo dos dados é apresentado sob a forma de média e desvio padrão para as variáveis contínuas e sob a forma de mediana com intervalo interquartil para as variáveis categóricas. Para a estatística inferencial, optou-se pelo recurso a testes não paramétricos, nomeadamente o Teste U de Mann Whitney, a Correlação de Spearman e o Teste de Qui-Quadrado. Definiu-se um nível de confiança de 95% ($p<0,05$), sendo a consistência interna do OHIP-14 para a amostra em estudo avaliada pelo cálculo do Alfa de Cronbach.

2.4 Procedimentos éticos

A participação no estudo cumpriu todos os preceitos preconizados na Declaração de Helsínquia, na Convenção de Oviedo e no Regulamento Geral de Proteção de Dados. A resposta ao instrumento de recolha de dados foi precedida da leitura do consentimento livre, esclarecido e informado, garantindo-se a confidencialidade e o anonimato dos dados recolhidos, sendo que a identificação do respondente nunca foi permitida ao longo da resposta ao instrumento de recolha de dados. Obteve-se decisão favorável da Comissão de Ética do Instituto Politécnico de Bragança, conforme Parecer nº60/2021.

3. RESULTADOS

Participaram no estudo 430 estudantes, maioritariamente do sexo feminino (n=342; 79.5%), de nacionalidade portuguesa (n=298; 69.3%) e com idade compreendida entre os 18 e os 22 anos (n=297; 69.1%). A caraterização académica dos participantes evidenciou que, predominantemente, estes frequentam um curso de licenciatura (n=420; 97.7%) e a Escola Superior de Saúde (n=326; 75.8%), sendo que 38.4% (n=165) frequentam o 1º ano e apenas 6.5% (n=28) o 4º ano.

Na caraterização da condição oral da amostra, verificou-se que 71.1% dos estudantes (n=306) têm antecedentes de patologia oral e 50.2% (n=216) têm zonas edêntulas, sendo que, destes, apenas 8.3% (n=18) usam mecanismos de substituição dentária. No que respeita às variáveis comportamentais (Tabela 1), a totalidade dos estudantes (n=430; 100.0%) refere escovar os dentes e a boca, sendo este hábito realizado duas ou mais vezes por dia por 85.4% da amostra (n=367). Contudo, 14.0% (n= 60) não frequenta consultas com profissionais de SO. Dos que o fazem com regularidade (n=188; 43.7%), a maioria frequentou uma consulta há menos de um ano (n=275; 64.0%), sendo a vigilância da saúde da boca (n=245; 56.9%) o principal motivo apontado. Quando questionados sobre o motivo da não frequência de consultas com profissionais de SO, as principais razões mencionadas foram o custo associado (n=119; 27.7%) e o medo (n=54; 12.6%).

Na caraterização dos determinantes da SO, verificou-se que a maioria dos estudantes não tem hábitos tabágicos (n=320; 74.4%) e que 48.6% (n=209) ingerem bebidas ou alimentos açucarados ocasionalmente, ainda que 45.1% (n=194) reconheçam o aumento da ingestão destes alimentos no período de estudo.

Tabela 1 - Distribuição da amostra segundo o sexo e as variáveis comportamentais

		Sexo				**Total**	
		Feminino		**Masculino**			
		n	**%**	**n**	**%**	**n**	**%**
Hábito de escovagem dos dentes e da boca	*Sim*	342	79.5	88	20.5	430	100.0
	Não	-	-	-	-	-	-
	Total	342	79.5	88	20.5	430	100.0
Frequência de escovagem dos dentes e da boca	*1 vez por dia*	35	8.1	28	6.5	63	14.6
	2 ou mais vezes por dia	307	71.4	60	14.0	367	85.4
	Total	342	79.5	88	20.5	430	100.0
Patologia oral	*Sim*	247	57.4	59	13.7	306	71.1
	Não	95	22.2	29	6.7	124	28.9
	Total	342	79.5	88	20.5	430	100.0
Frequência de consultas de SO	*Sim, com regularidade*	158	36.7	30	7.0	188	43.7
	Sim, quando é necessário	150	34.9	32	7.4	182	42.3
	Não	34	8.0	26	6.0	60	14.0
	Total	342	79.5	88	20.5	430	100.0
Hábitos tabágicos	*Sim, atualmente*	42	9.8	34	7.9	76	17.7
	Sim, anteriormente	26	6.0	8	1.9	34	7.9
	Não	274	63.7	46	10.7	320	74.4
	Total	342	79.5	88	20.5	430	100.0
Ingestão de bebidas ou alimentos açucarados	*Diariamente*	50	11.6	17	4.0	67	15.6
	A maioria dos dias	112	26.0	28	6.5	140	32.5
	Ocasionalmente	171	39.8	38	8.8	209	48.6
	Nunca	9	2.1	5	1.2	14	3.3
	Total	342	79.5	88	20.5	430	100.0
Aumento da ingestão de bebidas ou alimentos açucarados durante o estudo	*Sim*	151	35.1	43	10.0	194	45.1
	Não	191	44.4	45	10.5	236	54.9
	Total	342	79.5	88	20.5	430	100.0

Da análise correlacional das variáveis sociodemográficas com as variáveis comportamentais, constatou-se que a presença de patologia oral tem associação com significado estatístico com as variáveis Frequência de ingestão de bebidas ou alimentos açucarados (p=0.007) e Aumento da ingestão destes alimentos durante o período de estudo (p=0.019), havendo uma relação linear positiva entre estas variáveis. Verificou-se que há associação estatisticamente significativa entre a presença de zonas edêntulas e a frequência de consultas com profissionais de SO (p=0.008), sendo que os estudantes com edentulismo tendem a ser aqueles que menos têm este comportamento de procura de SO. A idade dos inquiridos é uma variável que se associa estatisticamente às variáveis Frequência de consultas com profissionais de SO (p=0.015), Uso de prótese dentária (p=0.000), Presença de zonas edêntulas (p=0.000) e Uso de tabaco (p=0.000), tendo uma relação linear negativa com todas, exceto com a frequência de consultas com profissionais de SO.

Ainda que a maioria dos estudantes autoavalie a SO em boa (n=226; 52.6%) ou muito boa (n=67; 15.6%), 67.4% (n=290) consideram que esta afeta muito ou moderadamente a sua qualidade de vida.

A avaliação da autoperceção da QdVRSO foi conseguida pela resposta ao OHIP-14 (Tabela 2), obtendo-se um *score* médio total de 6.142 (±9.137), com pontuações a variar entre o 0 e os 56 pontos, traduzindo ausência de impacto da SO na qualidade de vida dos estudantes. Em média, as dimensões mais pontuadas foram a Dor física (χ=1.423±1.648) e a Incapacidade psicológica (χ=1.119±1.780) e as menos pontuadas a Incapacidade social (χ=0.551±1.378) e a Desvantagem (χ=0.563±1.379). Estes resultados refletem a pontuação item por item, na medida em que os itens mais pontuados foram a sensação de dor (χ=0.719±0.897) e a sensação de desconforto durante a alimentação (χ=0.705±0.953) e os menos pontuados a perceção de incapacidade para desenvolver as atividades (χ=0.233±0.698) e a sensação de dificuldade em realizar as tarefas habituais (χ=0.251±0.698).

Gomes, M. J., & Ramos, O. M. (2022).
Qualidade de vida relacionada com a saúde oral em estudantes do ensino superior. *Millenium, 2*(18), 91-98.
DOI: https://doi.org/10.29352/mill0218.26599

A escala revelou ter uma consistência interna muito boa para a amostra em estudo, sendo o valor de Alfa de Cronbach para o OHIP-14 de 0.881, com intervalo para as dimensões de 0.580 a 0.915.

Tabela 2 - Autoperceção da QdVRSO

OHIP-14	Score				Impacto na QdV				Alpha de Cronbach
	Média (dp)	Mín.	Máx.	Variância	Com impacto		Sem impacto		
					n	%	n	%	
Dimensão 1 *Limitação Funcional*	0.705 (±1.500)	0	8	2.251	25	5.8	405	94.2	0.705
Dimensão 2 *Dor física*	1.423 (±1.648)	0	8	2.716	49	11.4	381	88.6	0.892
Dimensão 3 *Desconforto psicológico*	1.086 (±1.726)	0	8	2.979	44	10.2	386	89.8	0.899
Dimensão 4 *Incapacidade física*	0.695 (±1.399)	0	8	1.956	23	5.3	407	94.7	0.915
Dimensão 5 *Incapacidade psicológica*	1.119 (±1.780)	0	8	3.168	33	7.7	397	92.3	0.589
Dimensão 6 *Incapacidade social*	0.551 (±1.378)	0	8	1.898	19	4.4	411	95.6	0.822
Dimensão 7 *Desvantagem*	0.563 (±1.379)	0	8	1.902	22	5.1	408	94.9	0.580
OHIP-14 Total	6.142 (±9.137)	0	56	83.488	57	13.3	373	86.7	0.881

Do estudo correlacional entre as variáveis sociodemográficas e a autoperceção da QdVRSO, evidencia-se relação com significado estatístico entre a faixa etária dos estudantes e o *score* total do OHIP-14 (*p*=0.000), assumindo-se uma relação linear positiva entre estas variáveis (Correlação de Spearman com intervalo para as dimensões entre 0.151 e 0.242). De igual forma, o ano académico e a instituição de ensino têm associação estatisticamente significativa com o nível de QdVRSO autorreferido (*p*=0.001 e *p*=0.000, respetivamente), ainda que não existam diferenças estatisticamente significativas entre o ano académico e a média do *score* total do OHIP-14 (*p* superior a 0.05 para o Teste *t*).

Pela análise da correlação do nível de QdVRSO com as variáveis comportamentais, infere-se que há significado estatístico entre o *score* total do OHIP-14 e o número de escovagens dos dentes e da boca (*p*=0.000), a presença de patologia oral (*p*=0.000), a frequência de consultas com profissionais de SO (*p*=0.001), o uso de prótese dentária (*p*=0.000), o uso de tabaco (*p*=0.003), a ingestão de bebidas ou alimentos açucarados (*p*=0.040) e o aumento da ingestão destes produtos durante o período de estudo (*p*=0.000). À exceção da variável Frequência de consultas com profissionais de SO, todas as restantes apresentam uma relação linear negativa com o *score* total do OHIP-14 (Correlação de Spearman com intervalos entre -0.327 e -0.099), pelo que se constituem como comportamentos facilitadores de pior QdVRSO.

4. DISCUSSÃO

O conceito de QdVRSO é multidimensional, pelo que, na sua mensuração, é primordial a integração de fatores que ultrapassem o desconforto físico e a disfunção da cavidade oral e que contemplem as emoções e as funções sociais associadas à SO. Atualmente, os indicadores da SO espelham uma preocupação para a saúde pública, significando perda de anos de vida saudável e aumento dos custos em saúde pela prevalência da patologia oral nas comunidades (Direção-Geral da Saúde, 2021; FDI, 2015; Glick et al., 2012). Ainda que sensível a determinantes como os comportamentos de procura de SO, o *status* socioeconómico e a idade, o nível de SO determina a qualidade de vida, sendo este impacto consensual na revisão da literatura.

Nos estudantes do ensino superior o *status* de SO é relevante e tem reflexo ao longo da vida, sendo que há um conjunto de condições decorrentes dos desafios inerentes a esta etapa do ciclo vital que se apresentam como determinantes da SO. Paralelamente, considera-se que os fatores estéticos e funcionais decorrentes da condição oral do indivíduo afetam a vida social, a alimentação, o desempenho diário e o bem-estar, pelo que se torna relevante compreender a autoperceção da QdVRSO.

No estudo realizado, o *score* médio do OHIP-14 foi de 6.142 (±9.137) revelando ausência de impacto da SO na qualidade de vida. Esta evidência vai ao encontro de estudos anteriores que utilizaram como unidades de análise os estudantes do ensino superior (Dias et al., 2020; Drachev, Brenn & Trovik, 2018; Isiekwe et al. 2014; Luz, 2020; Yamane.Takeuchi et al., 2016). No entanto, este resultado é inconsistente com a condição oral encontrada na amostra e com os indicadores nacionais de SO que expõem a prevalência de patologia oral (Ordem dos Médicos Dentistas, 2021), o que faz transparecer a aparente subvalorização, pelos estudantes do ensino superior, do impacto da SO na qualidade de vida. Uzarevic e Bulj (2021), num estudo realizado na Croácia, objetivaram um *score* médio para o OHIP-14 ligeiramente superior ao da amostra em estudo, podendo esta diferença estar na dependência das caraterísticas sociodemográficas dos participantes e na forma como autodefinem saúde.

A dor física, a incapacidade psicológica e o desconforto psicológico foram as dimensões do OHIP-14 mais pontuadas, evidenciando o impacto da SO dos estudantes do ensino superior nas funções sociais. Gonzales-Sullcahuamán et al. (2013) e Yamane-Takeuchi et al. (2016), em estudos realizados em populações semelhantes, demonstraram que a dor física e o desconforto psicológico foram dimensões muito pontuadas, associando os resultados obtidos à prevalência da doença oral e ao impacto que o status de SO tem no desempenho das atividades diárias e na relação com o outro.

Os comportamentos de procura de SO são variáveis influenciadoras do nível de SO das populações e resultam da facilidade de acesso aos cuidados e do nível de literacia em saúde das populações. Nesta amostra prevalecem os estudantes com antecedentes de patologia oral e com zonas edêntulas. Este resultado não sobrepõe o expectável, na medida em que se trata de participantes com idades, maioritariamente, entre os 18 e os 22 anos e com competências que lhes permitem a procura de conhecimento, determinantes que se apresentam como facilitadores da procura de informação e da adoção de comportamentos protetores da SO. Ainda que os hábitos de higiene oral sejam adequados, que corroborem o evidenciado por Fortes et al.(2016) e por Sousa (2016) e que vão ao encontro do preconizado em diretivas nacionais (Direção-Geral da Saúde, 2019; 2021), a correlação das variáveis comportamentais com o *score* total do OHIP-14 ilustra o peso da negligência de comportamentos como a vigilância da condição de SO, a ingestão de alimentos ricos em açúcar ou a adição tabágica.

Os hábitos tabágicos e alimentares são determinantes modificáveis da SO. No presente estudo, a maioria dos inquiridos não tem hábitos tabágicos, mas ingere bebidas ou alimentos açucarados, sendo que, à semelhança do estudo de Luz (2020), os estudantes que consomem frequentemente estes alimentos autorrelataram maior impacto da SO na qualidade de vida. De acordo com a FDI (2015), o consumo excessivo de alimentos ricos em açúcar é promotor do aparecimento de cárie dentária e de doença periodontal, condições de saúde com impacto nas funções física, funcional e social do indivíduo e com significado no conforto, na autoimagem, na autoestima e no bem-estar. Atendendo à evolução das políticas nacionais de SO e às caraterísticas sociodemográficas da amostra, esperava-se um menor impacto dos determinantes da SO na QdVRSO, resultado que reitera a pertinência do estudo desta variável para a definição de estratégias direcionadas às necessidades sentidas pelo indivíduo.

No que respeita à procura de cuidados de SO, verificou-se que a maioria dos estudantes não frequenta consultas com profissionais de SO ou fá-lo apenas quando necessário, sendo o custo associado aos cuidados e o medo os principais motivos de não procura. Estes resultados espelham o demonstrado pela Ordem dos Médicos Dentistas (2021) e por Monteiro (2018) e evidenciam a premência do alargamento de medidas que promovam a equidade no acesso aos cuidados de SO e a integração efetiva destes cuidados no Serviço Nacional de Saúde.

CONCLUSÃO

A pontuação média do OHIP-14 reflete a ausência de impacto da SO na qualidade de vida dos estudantes do ensino superior que participaram no estudo. As dimensões mais pontuadas foram a Dor física e a Incapacidade psicológica, inferindo-se que a SO é multidimensional e que determina condições de desconforto, disfunção física, sofrimento psicológico e diminuição do bem-estar. Esta evidência reitera a pertinência da integração da avaliação da QdVRSO na avaliação global do status de SO, sendo que esta é uma variável de resultado que oferece contributos para a definição de estratégias centradas no indivíduo e promotoras da SO.

Concluiu-se que os comportamentos em SO têm significado na QdVRSO, sendo que a negligência da procura de cuidados de SO tem impacto negativo na qualidade de vida de estudantes do ensino superior. Deste facto, emerge a necessidade da implementação de estratégias mais abrangentes que integrem *settings* populacionais desfavorecidos no que respeita à SO. Em Portugal, apesar da evolução de medidas promotoras da equidade no acesso aos cuidados de saúde, há ainda um hiato entre as necessidades em SO e a oferta de cuidados, sendo que os custos associados a estes são, efetivamente, um obstáculo na promoção da SO. Assim, considera-se premente a integração efetiva dos cuidados de SO no Serviço Nacional de Saúde e a aferição de indicadores que ultrapassem a morbimortalidade.

Reconhecem-se como limitações do estudo o tamanho da amostra, por não permitir a generalização dos dados para a população de estudantes do ensino superior, e a limitação a uma área geográfica, pelo que se sugere a realização de estudos mais abrangentes e que integrem variáveis como o *status* socioeconómico, a rede de cuidados de SO e os recursos e estratégias de promoção da SO disponibilizados pelas instituições de ensino.

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ESTADO NUTRICIONAL E CONSUMO ALIMENTAR DE CRIANÇAS MENORES DE CINCO ANOS, MULHERES GRÁVIDAS E LACTANTES APÓS O CICLONE IDAI

NUTRITIONAL STATUS AND FOOD CONSUMPTION OF CHILDREN UNDER FIVE YEARS, PREGNANT AND LACTATING WOMEN AFTER CYCLONE IDAI

ESTADO NUTRICIONAL Y EL CONSUMO DE ALIMENTOS DE LOS NIÑOS MENORES DE CINCO AÑOS, DE LAS MUJERES EMBARAZADAS Y LACTANTES TRAS EL CICLÓN IDAI

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RESUMO

Introdução: O ciclone Idai criou graves mudanças no nível de vida da população em Dombe, Moçambique

Objetivo: Avaliar o estado nutricional e caracterizar o consumo alimentar de crianças menores de cinco anos de idade e de mulheres grávidas e lactantes (MGL).

Métodos: Estudo transversal com amostra probabilística por conglomerados complementada por amostra aleatória simples. Foi avaliado o estado nutricional de crianças e MGL através da pesagem, medição da estatura e do perímetro braquial e caracterização da frequência alimentar por meio de aplicação de questionários de frequência alimentar (QFA).

Resultados: Nas crianças menores de cinco anos de idade, houve uma prevalência de desnutrição aguda grave de 2,1% e desnutrição aguda moderada, 4,1%. Em relação à desnutrição crónica grave, a prevalência foi de 19,8% e desnutrição crónica moderada, 22,1%. O baixo peso grave foi de 3,6% e o baixo peso moderado, 7,8%. A prevalência de sobrepeso foi de 7,7% e de obesidade 1,8%. Quanto às mulheres grávidas e lactantes 4,7% foram diagnosticadas com desnutrição aguda moderada. O consumo alimentar de ambas as populações em estudo é caracterizada por consumo de cereais e derivados, vegetais e peixe seco ou de rio.

Conclusão: o estado nutricional das crianças e MGL é normal, contudo foram registados casos de malnutrição. O consumo alimentar de ambas populações não é equilibrado.

Palavras-chave: crianças; desnutrição; mães grávidas e lactantes; reassentamento

ABSTRACT

Introduction: Cyclone Idai triggered severe changes in the living standards of the population in Dombe, Mozambique.

Objective: To assess the nutritional status, and characterise food consumption of children under five years of age and pregnant and lactating women (PLW).

Methods: Cross-sectional study with probabilistic sampling by conglomerates complemented by simple random sampling. The nutritional status of children and PLW was assessed by weighing, measuring height and brachial perimeter and characterising food consumption by applying food frequency questionnaires (FFQ).

Results: In children under five years of age, there was a prevalence of severe acute malnutrition of 2.1% and moderate acute malnutrition, 4.1%. Regarding severe acute malnutrition, the prevalence was 19.8% and moderate acute malnutrition, 22.1%. Severe low weight was 3.6% and moderate low weight, 7.8%. The prevalence of overweight was 7.7% and obesity 1.8%. Pregnant and lactating women were diagnosed with moderate acute malnutrition (4.7%). Food consumption in the populations is characterised by the consumption of cereals and derivatives, vegetables and dried or river fish.

Conclusion: Nutritional status of children and PLW is normal, however cases of malnutrition were observed. Food consumption of both populations is unbalanced.

Keywords: children; malnutrition; pregnant and lactating mothers; resettlement

RESUMEN

Introducción: El ciclón Idai provocó graves cambios en el nivel de vida de la población en Dombe, Mozambique.

Objetivo: evaluar el estado nutricional y caracterizar el consumo de alimentos de los niños menores de cinco años y de las mujeres embarazadas y lactantes (MEL).

Métodos: Estudio transversal con muestreo probabilístico por conglomerados complementado con un muestreo aleatorio simple. El estado nutricional de los niños y de las MEL se evaluó mediante el pesaje, la medición de la altura y el perímetro braquial y la caracterización de la frecuencia alimentaria mediante la aplicación de cuestionarios de frecuencia alimentaria (CFA).

Resultados: En los niños menores de cinco años, hubo una prevalencia de desnutrición aguda severa del 2,1% y de desnutrición aguda moderada, del 4,1%. En cuanto al retraso severo en el crecimiento, la prevalencia fue del 19,8% y el retraso moderado, del 22,1%. La insuficiencia ponderal grave era del 3,6% y la moderada, del 7,8%. La prevalencia de sobrepeso era del 7,7% y la de obesidad del 1,8%. Las mujeres embarazadas y lactantes fueron diagnosticadas con desnutrición aguda moderada (4,7%). El consumo de alimento de las poblaciones se caracteriza por el consumo de cereales y derivados, verduras y pescado seco o de río.

Conclusión: El estado nutricional de los niños y MEL es normal, sin embargo, se registraron casos de desnutrición. El consumo de alimentos de ambas poblaciones es desequilibrado.

Palabras Clave: niños; desnutrición; madres embarazadas y lactantes; reasentamiento

INTRODUCTION

Central region of Mozambique was devastated by Cyclone Idai in 2019, causing a humanitarian disaster. The Cyclone was of intensity 4 on the Saffir-Simpson scale, with winds of more than 240 km/h, accompanied by heavy rainfall of 200 mm/24hours. Shortly afterwards, some districts in northern region of the country (Cabo-Delgado and Nampula) were also hit by Cyclone Kenneth (Matos & Ndapassoa, 2020). Cyclone Idai was devastating, and affected health, infrastructural, educational, economical and agricultural sectors. Cyclones Idai and Kenneth created widespread flooding, destruction of almost 780,000 hectares of agricultural crops and the displacement of tens of thousands of families in northern and central Mozambique. There was also loss of lives. Unavailability of food in acceptable quantity and quality has negative effects, particularly on children, pregnant and lactating women (PLW), as their tolerance to nutrients shortage is minimal (Chamova & Dimitrova, 2020). Number of children under five facing crisis of food insecurity was expected to rise to 200,000 in areas affected by natural disasters by February 2020 and about 38,000 children could become extremely malnourished and at risk of death in the same period (UNICEF, 2019). The aim of this study was to assess nutritional status and characterize food consumption of children under five years of age and PLW residing in resettlement centres in Dombe, Mozambique, after Cyclone Idai in 2019.

1. LITERATURE REVIEW

Food and nutritional insecurity (FNI) are public health problems. Several factors may contribute to occurrence of FNI, such as food shortages, food supply problems, insufficient food production, loss of income, poverty, rising food prices, and climate change, which currently cause floods and Cyclones. Food availability and quality are indirect indicators of FNI (Coelho et al., 2015). FNI has physical or biological consequences for individuals, such as low weight and/or nutritional deficiencies (Kepple & Segall-Corrêa, 2011). Access to food (known as food security) is not lonely sufficient. Food must be safe (known as food safety). *Food security* expresses the guarantee of access to food consumption and covers the whole set of needs for obtaining adequate nutrition for health. F*ood safety,* on the other hand, implies a guarantee of safe food in terms of collective health, i.e., products free of chemical (agrochemicals), biological (pathogenic organisms), physical agents (sand, pieces of glass, iron) or other substances which could pose a risk to health (Matos & Ndapassoa, 2020).

Most population in Mozambique rely on subsistence agriculture; other, also on informal trade. However, cyclone Idai caused total and/or partial destruction of farms and infrastructure and loss of livestock, increasing vulnerability of children under five and PLW in terms of food acquisition and health. Children undernutrition remains a serious problem in developing countries, poor food intake being one of major cause (Khamis et al., 2019). The "first 1,000 days" period of life, known as the window of opportunity, is an important stage to optimize child growth and development in order to prevent malnutrition, including wasting, underweight and stunting, as well as the negative consequences in adulthood (Ahmad et al., 2018). Undernutrition is also a major cause of anaemia. Mild forms of micronutrient malnutrition and anaemia can have negative consequences for health and development. Severe anaemia is often associated with increased maternal mortality, pre-mature birth, low birth weight, and impaired child development (Petry et al., 2019). Food intake optimizes child development, and performance. Yet, an estimated number of 250 million children under five years of age from low- and middle-resource settings (43%) will not achieve their full developmental potential due to social, economic, nutritional, and learning opportunity constraints (Villar et al., 2019).It was estimated that undernutrition is associated with 45% of child deaths. Additionally, globally in 2020, 149 million children under five were estimated to be stunted (too short for age), 45 million were estimated to be wasted (too thin for height), and 38.9 million were overweight or obese (WHO, 2021). Nutritional status of pregnant women predefines the physiological profile of the future adult. Many pathological conditions in adult are the consequence of nutritional ground of an individual in intrauterine life. Thus, occurrence of malnutrition events in pregnant women may trigger irreversible problems for the new-born (Wu et al., 2014).

Displacement of people due to natural disasters, contributes to deteriorating living conditions and food imbalance, as it triggers economical losses (Abbas Khan et al., 2019). Precariousness of living conditions may have worsened with the outbreak of the COVID-19 pandemic in December 2019, as the availability and access of water and food became increasingly unsustainable. Indeed, the State of Food Security and Nutrition in the World (SOFI) cited by UNICEF (2021) indicated that nearly one-tenth of the world population – up to 811 million people went hungry in 2020. Further, it is projected that around 660 million people may still face hunger in 2030, 30 million more people than in a scenario in which the pandemic had not occurred, due to lasting effects of COVID-19 on global food security, making the achievement of the Sustainable Development Goal for zero hunger and ending all forms of malnutrition more challenging (UNICEF, 2021).

2. METHODS

Cross-sectional study with probabilistic sampling by conglomerates complemented by simple random sampling. The nutritional status of children and PLW was assessed by weighing, measuring height and brachial perimeter and characterising food consumption by applying food frequency questionnaires (FFQ).

2.1 Local

The study was conducted between September and December 2020 in the resettlement centres of Muwawa, Bairro Unidade, Magaro, Macocoe, Mucombe, Nhanhemba-2, Madibunhana, Tussene Shoma and Matarara, located in Dombe, Sussundenga, Manica province, central region of Mozambique.

2.2 Sample

Total number of residents in the resettlement centres is 10,688 (minimum 420 and maximum 1,938 people) grouped in 2,040 families. Children under five years of age and PLW residing in the resettlement centres are 2672 and 1779 respectively. Firstly, we calculated overall sample of the children and PLW. From this sample, we determined corresponding number of individuals in each centre resulting in: (i) 339 children under five years of age of both sexes (whose survey was answered by a caregiver) and (ii) 319 pregnant and lactating women. Conglomerate sampling technique was applied, followed by simple random sampling.

2.3 Data Collection Procedures and Instruments

Child caregivers and pregnant and lactating women were face-to-face surveyed by administration of survey forms, consisting of closed- and open-ended questions to collect data relating to gender and age of children, and education for pregnant and lactating women. Nutritional status was assessed by weighing, measuring height and brachial perimeter using scales, stadiometer and brachial perimeter tape, respectively (weighing scale SECA, max weight: 150 kg, Mfd. 2016), height (stadiometer, electromed Ltd, precision 0.1, max height: 210 cm), arm length and skin folds of triceps and sub scapularis (adipometer CIMA, max fold: 20 mm, Mfd. 2015). For PLW only the brachial perimeter was measured. Indicators used to assess the nutritional status were weight-for-height, height-for-age and weight-for-age. For weight-for-height indicator, the cohort points used were: SAM - Severe Acute Malnutrition (< z-score -3); MAM - Moderate Acute Malnutrition (> z-score -3 and < z-score -2); Adequate or normal weight (> z-score -2 and < z-score +2); Overweight (> z-score +2 and < z-score +3); Obesity (> z-score +3). For weight-for-age, SLW - Severe Low Weight (< z-score -3); MLW - Moderate Low Weight (> z-score -3 and < z-score -2); Adequate or normal weight (> z-score -2 and < z-score +2) and for height-for-age, SCM - Severe Chronic Malnutrition (< z-score -3); MCM - Moderate Chronic Malnutrition (> z-score-3 and < z-score -2); Age-appropriate or normal height (≥ z-score -2). For PLW, SAM: > 21cm; MAM: > or = 21cm and <23 cm. Source: WHO, 2006; adapted by (PUC Goiás, 2013).

We applied Food Frequency Questionnaire (FFQ) as an instrument to collect information regarding to food consumption of families with pregnant and lactating women and children under five years old. In addition, breastfeeding and food intake was explored from the same group. We analysed frequency of consumption of cereals and derivatives, tubers, legumes and nuts, milk and derivatives, meat and eggs, fish and shellfish, vegetables, fruits, oils and fats, sweets and salty snacks and beverages, in the last three months to the date of study. Frequency of consumption was categorized as: once a day, 2 or more times a day, once a week, 2 to 4 times a week, 5 to 6 times a week, 1 to 3 times a month and never.

2.4 Inclusion Criteria and Ethics

To be children under five years of age and pregnant or lactating women or child caregiver, residing in the resettlement centres in the Dombe, Mozambique.

The study had approval from Bioethics Committee of Lúrio University with registration no 31.1/Feb/CBISUL/20 and all ethical procedures were observed based on the World Medical Association Helsinki Declaration of Ethics, Principles for Medical Research Involving Human Subjects, 2013.

2.5 Statistical Analysis

The data were treated using descriptive and inferential statistics. Frequencies were calculated using the statistical package *Jamovi* version 1.2.27, and tables were constructed using MS Excel. The confidence level set was 95% and a cut-off value of 0.05 for the p-value. Shapiro-Wilk normality tests for weight, height and brachial perimeter, *t-test* for independent samples, ANOVA and chi-square were performed.

3. RESULTS

54.9% (n=186) children under five years of age are female and 45.1% (n=153) are male. Their age ranged from 6 to 59 months. The average height of children is 78.5 cm (minimum 54.8 and maximum 109 cm) and weight is 10.7 kg (minimum 5.9 and maximum 19.1 kg). The mean of brachial perimeter is 15 cm (minimum 10.5 and maximum 20.5 cm). Shapiro-Wilk normality test indicated that the values of height and brachial perimeter do not follow a normal distribution ($p<0.05$), while the values of weight of same children follow a normal distribution ($p>0.05$).

A total of 319 pregnant and lactating women (PLW) aged 16 to 46 years old (mean 26.5) were included. Of them, 53.3% (n=170) have primary education, 38.6% (n=123) have no education, 6.3% (n=20) have basic education, while only 1.9% (n=6) have medium education. Yet, many of the women could not read or write.

Nutritional Status of Children Under Five Using the *Weight-for-height* Indicator

We used *weight-for-height* indicator to evaluate acute malnutrition, overweight and obesity. The diagnosis indicated that most children (84.4%, n=286) are eutrophic or normal. However, 2.1% (n=7) children were diagnosed with severe acute malnutrition (SAM) and 4.1% (n=14) moderate acute malnutrition (MAM). On the other hand, 7.7% (n=26) is overweight and 1.8% (n=6) obese (Table 1).

Chi-square test showed statistically significant relationship between gender and prevalence of acute malnutrition in children under five years of age (p>0.05). Female had relatively greater tendency to develop cases of acute malnutrition. As for the degree of severity by gender, SAM was recorded only on female (100%, n=7). For MAM, it was also female who presented higher prevalence (57.1%, n=8) when compared to male (42.9%, n=6). Additionally, females presented higher prevalence of overweight 65.4% (n=17), while for males it was 34.6% (n=9). Regarding to obesity both genders presented equal prevalence (50% each). ANOVA test showed that there is a correlation between acute malnutrition and brachial perimeter of children under five years old (p>0.05), indicating that this measure was viable for the evaluation of acute malnutrition. We, then, test whether or not there is a correlation between low weight and acute malnutrition in children, and no correlation was found between the two variables (p<0.05).

Table 1 - Diagnosis of children in the resettlements based on the indicator "Weight-for-height".

	Resettlement								
Weight-for-height	**Bairro Unidade**	**Macocoe**	**Madibunhana**	**Magaro**	**Matarara**	**Mucombe**	**Muwawa**	**Nhanhemba 2**	**Tussene Shoma**
SAM (p=0.05)	0	0	2.3% (n=1)	2.2% (n=1)	4.5% (n=1)	0	0	1.8% (n=1)	5.9% (n=3)
MAM (p=0.05)	0	0	2.3% (n=1)	15.6% (n=7)	0	0	4.2% (n=2)	3.6% (n=2)	3.9% (n=2)
Normal (p=0.05)	80.5% (n=33)	89.5% (n=17)	88.6% (n=39)	66.7% (n=30)	95.5% (n=21)	100% (n=14)	87.5% (n=42)	87.3% (n=48)	82.4% (n=42)
Overweight (p=0.05)	19.5% (n=8)	0	4.5% (n=2)	13.3%(n=6)	0	0	8.3% (n=4)	5.5% (n=3)	5.9% (n=3)
Obesity (p=0.05)	0	10.5% (n=2)	2.3% (n=1)	2.2% (n=1)	0	0	0	1.8% (n=1)	1.9% (n=1)

SAM – Severe acute malnutrition (< z-score -3); MAM – Moderate acute malnutrition (> z-score -3 e < z-score -2); Eutrophic or Normal (> z-score -2 e < z-score +2); Overweight (> z-score +2 e < z-score +3); Obesity (> z-score +3). Fonte: OMS, 2006; adapted from (PUC Goiás, 2013).

Nutritional Status of Children Under Five Using the Weight-for-Age Indicator

Weight-for-age indicator showed that most children have appropriate weight for their age. However, severe low weight (SLW) was diagnosed (3.6%; n=12) and moderate low weight (MLW), 7.8% (n=26) (Table 2). Females presented the highest rates of MLW with 65.4% (n=17) compared to 34.6% (n=9) for males, and for SLW with 75% (n=9) compared to 25% (n=3) males.

Table 2 - Diagnosis of children in the resettlements based on the indicator "Weight-for-age".

	Resettlement								
Weight-for-age	**Bairro Unidade**	**Macocoe**	**Madibunhana**	**Magaro**	**Matarara**	**Mucombe**	**Muwawa**	**Nhanhemba 2**	**Tussene Shoma**
SLW (p=0.05)	2.4% (n=1)	0	4.5% (n=2)	4.4% (n=2)	0	0	4.2% (n=2)	3.6% (n=2)	5.9% (n=3)
MLW (p=0.05)	7.3% (n=3)	0	0	20% (n=9)	9.1% (n=2)	0	14.6% (n=7)	1.8% (n=1)	7.8% (n=4)
Normal (p=0.05)	90.2% (n=37)	100% (n=19)	95.5% (n=42)	64.4% (n=29)	90.9% (n=20)	100% (n=14)	81.3% (n=39)	94.5% (n=52)	86.3% (n=44)

SLW– Severe low weight (< z-score -3); MLW – moderate low weight (> z-score -3 e < z-score -2); Normal (> z-score -2 e < z-score +2). Source: WHO, 2006; adapted from (PUC Goiás, 2013).

Nutritional Status of Children Under Five Using the *Stature-for-Age* Indicator

Although most of the children had ideal stature in relation to their age (84.4%, n=286) cases of chronic malnutrition were also diagnosed (n=142). As for the degree of severity, prevalence of severe chronic malnutrition (SCM) was 19.8% (n=67) and that of moderate chronic malnutrition (MCM), 22.1% (n=75), indicating that the children are below ideal stature for their age (Table 3). Statistically significant association was found between gender and the development of chronic malnutrition in children (p>0.05). Female had a higher rate of chronic malnutrition. Regarding the degree of severity, it was also the females who presented the highest prevalence of SCM (56.7%, n=38) and (43.3%, n=29) for males. Number of cases of MCM, showed no difference between male and female.

Table 3: Diagnosis of children in the resettlements based on the indicator "Stature-age".

Stature-Age				**Resettlement**					
SCM (p=0.05)	36.6% (n=15)	10.5% (n=2)	11.4% (n=5)	31.1% (n=14)	13.6% (n=3)	21.2% (n=3)	27.1% (n=13)	7.3% (n=4)	15.7% (n=8)
MCM (p=0.05)	21.9% (n=9)	15.8% (n=3)	13.6% (n=6)	31.1% (n=14)	18.2% (n=4)	7.1% (n=1)	33.3% (n=16)	16.4% (n=9)	25.5% (n=13)
Normal (p=0.05)	41.5% (n=17)	73.7% (n=14)	75% (n=33)	35.6% (n=16)	68.2% (n=15)	71% (n=10)	39.6% (n=19)	76.4% (n=42)	58.2% (n=30)

SCM - Severe Chronic Malnutrition (< z-score -3); MCM - Moderate Chronic Malnutrition (> z-score -3 and < z-score -2); Adequate height for age or normal (≥ z-score -2). Source: WHO, 2006; adapted by (PUC Goiás, 2013).

Nutritional status of pregnant and lactating women

Brachial perimeter was measured for pregnant and lactating women, and 4.7% was diagnosed with moderate acute malnutrition. [SAM: > 21cm; MAM: > or = 21cm and <23 cm].

Breastfeeding habits for Children Under Five Years Old

Almost all respondents (99.7%, n=338) reported that the first food given to the baby was breast milk. Only one respondent also mentioned water. By the time of study, 43.7% (n=148) respondents reported that their children were not taking breast milk. Others (56.3%, n=191) fed them cow's milk. Relating to children's age, the majority (92.1%, n=176) were in the interval from 6 to 23 months of age and of those who did not take milk, 89.9% (n=133) pointed that the babies were between 24 and 59 months of age. For those who answered "no breast milk", they were asked at how many months the child had stopped taking milk. About 127 respondents (86.4%) stated that they had weaned from 13 months of age (Table 4).

Table 4 - Breastfeeding of children under five years of age

Does the child drink breast milk?	**Yes**	**No**
	56.3% (n=191)	43.7% (n=148)
If answered "no" how long did you stop breastfeeding?	n	%
13+ months	127	86.4
7-12 months	18	12.2
3-6 months	3	2

Mothers' knowledge About Good Breastfeeding and Regular Feeding Practices

We sought to explore knowledge on the benefits of exclusive breastfeeding in the first six months of life. The data indicated that most of participants knew about the nutritional role of breast milk (63,7%; n=216), but did not know its protective role (77.9%, n=244). More than half respondents 56.6% (n=192) gave liquids at six months of age, but one of the respondents referred she gave other liquids on the very first day of life. Regarding to porridge consumption, 72.6% (n=246), said they started at the sixth month of age and only two (0.6%) said at twelve months. Most caregivers (49.0%, n=166) provide three meals a day to their children. Other 26.0% (n=88) provide two meals, while 13.3% (n=45) provide only one meal (Table 5) showing an incomplete feeding pattern (Table 5). In the last 24 hours of data collection, mothers or caregivers did not include fruit, bean soup (321, n=94.4%) or vegetable soup (95.3%, n=323) in the children's food.

We explored whether or not there are foods they consider to be good for children. Of the respondents, 285 (84.1%) answered affirmatively, and as example they mentioned rice, beans, breast milk, sweet potato, fruit, yam, cassava, *xima*, bread, fish, while the remaining 54 (15.9%) said there were no such food stuff. In turn, in relation to foods that should not be consumed, 308 (90.9%) respondents stated that there are not.

Table 5 - Children's first consumption of liquid, porridge and number of meals per day

First consumption of liquids	Frequency	First consumption of porridge by children	Frequency	Number of meals per day	Frequency
Do not know	1 (0.3%)	N/A	1 (0.3%)	1	45 (13.3%)
One day	1 (0.3%)	No food	2 (0.6%)	2	88 (25.9%)
14 days	1 (0.3%)	2 months	3 (0.9%)	3	166 (48.9%)
1 month	4 (1.2%)	3 months	14 (4.1%)	More than 3	39 (11.5%)
2 months	17 (5%)	4 months	18 (5.3%)	N/A	1 (0.3%)
3 months	57 (16.8%)	5 months	11 (3.2%)		
4 months	32 (9.4%)	6 months	246 (72.6%)		
5 months	25 (7.4%)	7 months	26 (7.7%)		
6 months	192 (56.7%)	8 months	12 (5.3%)		
7 months	8 (2.4%)	9 months	2 (0.6%)		
8 months	1 (0.3%)	12 months	2 (0.6%)		

N/A – not applicable

Women's perception of food intake during pregnancy and lactation

Most PLW (93.4%, n=298) said there are no foods bad for pregnant individuals. We also found that another portion (72.7%, n=232) did not have enough knowledge about healthy foods to be consumed during pregnancy. Furthermore, there are widespread principles such as, when consuming certain foods, *the foetus may slip or the baby be born sick; or it may cause early uterine contractions*. Finally, the majority (83.1%, n=265) also pointed the existence of feeding practices to promote health after childbirth and improve lactation. These practices included the ingestion of certain foods such as drinking tea with milk, *maheu,* consumption of *cocoa* and fruits, fresh and dried fish. Other practices such as boiling water to drink, performing less strenuous work and intensifying personal hygiene, administering porridge, going to the healer were also mentioned. In case of lactation failure, women have resorted to formula feeding (69.8%, n=220) and hospital in addition to formula milk (15.3%, n= 48). Only a small proportion (4.4%, n=14) referred to go exclusively to the hospital. There are also 7 (4.4%) respondents who don't know what to do in case of lactation problems.

Food Consumption Frequency of the Population in Resettlement Centres

Food frequency questionnaire (FFQ) was applied to families with pregnant and lactating women and children under five. We analysed frequency of food consumption three months prior to data collection. We used the parameters: *once a day, 2 or more times a day, 1 time a week, 2 to 4 times a week, 5 to 6 times a week, 1 to 3 times a month and never* to classify frequency of consumption of cereals and derivatives, tubers, legumes and nuts, milk and derivatives, meat and eggs, fish and shellfish, vegetables, fruits, oils and fats, sweets and salty snacks and beverages. We classified consumption as low, moderate or high if consumption of particular food item, based on the consumption average of approximately 50%, giving to its nutritional importance, and conjugating with the parameters we have fixed and number of food item in a certain group.

For the group of cereals and derivatives, data indicated that maize (70.5%, n=225) and maize flour (70.2%, n=224) were most consumed during the period in reference. The remaining items in this group were consumed with less or moderate frequency. Before Cyclone Idai frequency of maize and maize flour consumption was the same for 82.1% (n=262) respondents. Among tubers, only sweet potato was consumed moderately with a tendency to high (48.3%, n=154) and before the Cyclone frequency of consumption was the same for 59.6% (n=190) respondents. Legumes and nuts are not consumed very frequently. In this group, the most consumed food item was butter beans (41.4%, n=132). Compared to the period before Cyclone, frequency of consumption was the same for 33.2% (n=106).

Frequency of consumption of milk and its derivatives was much lower in the population. For instance, the highest frequency of condensed milk was 16% (n=51), cow's milk 4.1% *(n=13),* powdered milk 21% (n=67). Cheese and yogurt were almost not consumed neither before nor after Cyclone (below 2%). Consumption of meat and eggs, in general, was low with goat meat being the most consumed (35.4%, n=113). Frequency was similar to the period before the Cyclone for 70.8% (n=226). Consumption of chicken egg was moderate. About 32% (n=103) stated they consumed once a week, 29.8% (n=95) two or more times a week and before Cyclone Idai, frequency was the same for 44.5% (n=142) respondents. Freshwater fish was the most consumed food in the group of fish and crustaceans, with frequency of 40.1% (n= 128). Equal frequency was seen for 52.4% (n=167) respondents before Cyclone.

Consumption of vegetables, in general, was low. The most consumed vegetables were tomato and onion (53.9%, n=172, similar frequency for both). Similarly, before Cyclone Idai the frequency of tomato and onion consumption was the same for 67.7% (n=216) participants. On the other hand, consumption of potato and cabbage leaves was low tending to moderate (36.1%, n=114).

Overall consumption of fruits was also low. Only mangoes were the most consumed (93%, n=296) by the respondents. Similar frequency was observed for 84.6% (n=270) before Cyclone Idai.

Consumption of fats and oils was also low, except for vegetable oil. Consumption of vegetable oil was higher, as most participants (91.8%, n=293) reported consuming it two or more times a day. This scenario was different from that before Cyclone Idai, where frequency was lower for 74.6% (n=238). Regarding to pumpkin seeds, the consumption was much lower as 89% (n=284) said they never consumed.

Consumption of sweets and salty snacks was generally low. Sugar and cake were consumed by 31.7% (n=101), while consumption of savoury snacks was higher. Consumption of fried dumplings was relatively higher as most of women (38.2%, n=122) consumed once a week, 24.1% (n=77) two or more times a day. Before Cyclone Idai the frequencies were the same for 56.7% (n=181). Consumption of *snacks* (e.g., *filos, doritos*) was moderate as of those who consumed, 33.5% (n=107) did once a week and 10.7% (n=34) two to four times a week. Frequencies are similar with those in the period before Cyclone Idai for 71.8% (n=229). Regarding to beverages, consumption of this group was generally moderate. For instancy, consumption of soft drinks was low as 154 respondents (48.3%) consumed once a week, 41 (12.9%) two to four times a week. Frequencies before Cyclone Idai were the same for 62.7% (n=97) respondents. Alcoholic beverages were not frequently consumed by pregnant and lactating women (less than 6%). Equal frequencies were recorded before Cyclone Idai for 96.9% (n=309) (Table 6).

Table 6 - Food consumption by each food group in families with pregnant and lactating women and children under five before and after Cyclone Idai.

Food group	Food representative	Food consumption after Idai (%)	Food consumption before Idai (%)
Cereals and derivatives	Corn	70,5%, n=225	Equal for 82,1% (n=262) Hihg for 6,6% (n=21) Low for 11,3% (n=36)
	Corn flower	70,2%, n=224	Similar as for corn
Tubers	Sweet potato	48,3%, n=154	Equal for 59,6% (n=190) Low for 30,7% (n=98) High for 9,7% (n=31)
Lugumes and nuts	Butter beans	41,4%, n=132	Equal for 33,2% (n=106) Low for 62,4% (n=199) High for 14 (4,4%)
Milk and dairy products	Cow's milk and powdered milk	16% (n=51), leite de vaca 4,1% (n=13), leite em pó 21% (n=67)	No relevant variation
Meat and eggs		35,4%, n=113	Equal for 70,8% (n=226) Low for 16,6% (n=53) High for 12,5% (n=40)
	Hen egg	32%, n=103	Equal for 44,5% (n=142) Low for 43,6% (n=139) High for 11,9% (n=38)
Fish and crustacean	Freshwater fish	40,1%, n= 128	Equal for 52,4% (n=167) Low for 43,6% (139) High for 4,1% (n=13)
Horticultural products	Tomatoes and onion	53,9%, n=172	Equal for 67,7% (n=216) Low for 27,9% (n=89) High for 4,4% (n=14)
Fruits	Mango	93%, n=296	Equal for 84,6% (n=270) Low for 6,6% (n=21) High for 8,8% (n=28)
Fats and oils	Vegetable oil	91,8%, n=293	Equal for 21,3 % (n=68) Low for 74,6% (n=238) High for 4,1% (n=13)
Sweets and savouries	Sugar and cakes	31,7%, n=101	No relevant variations
	Savouries	38,2%, n=122	No relevant variations
	Fried dumplings	38,2%, n=122	Equal for 56,7% (n=181) Low for 39,2% (n=125) High for 4,1% (n=13)
Beverages	Soft drink	48,3%, n=154	Equal for 62,7% (n=97) Low for 32% (n=102) High for 5,3% (n=17)
	Alcoholic beverages	3,4%, n=11	Equal for 96,9% (n=309) low for 96,9% (n=309) High for 1,3% (n=4)

4. DISCUSSION

We sought to assess nutritional status and characterize food consumption of populations residing in resettlements in Dombe, Mozambique. Mobility of populations due to Cyclone has increased population’s vulnerability due to (1) inability to regularly practice subsistence activities and (2) economic imbalance. These factors affected food security and quality of life, as the practice of agriculture and other profitable activities were affected and economic disparities arose causing shortage of food access, particularly for children and women. Similarly, Silva and Lage (Silva & Lage, 2020) describe in a study that low income has affected women’s food consumption, and triggered dietary monotony.

In this study, acute and chronic malnutrition, overweight and obesity were diagnosed in children. Although it is not yet possible to relate these pathological conditions with prior malnutrition events in the same children, literatures stresses that there is a recovery mechanism which the body of an undernourished individual triggers. In certain cases, children with malnutrition tend to be obese or overweight afterwards (El et al., 2006). Here, we found a prevalence of severe acute malnutrition of 2.1% and of moderate acute malnutrition, 4.1% in children. In a study analysing children aged 6 - 59 months in rural Mozambique, a prevalence of 5.11% for acute malnutrition was found using a Standardized Monitoring and Assessment for Relief and Transition (SMART) nutrition survey and 3.58% in a Rapid Nutrition Assessment (RNA) survey (Zaba et al., 2021). Mozambique, just as other countries, is struggling with the issue of food transition and double burden of “malnutrition–obesity”, which translates into the paradox of increasing cases of undernourishment and overweight. In fact, while hunger kills more people every year than malaria, tuberculosis and HIV-AIDS combined (45% of infant deaths are related to malnutrition), ironically obesity is rising everywhere at an accelerating pace (Larrosa-haro & Caro-sabido, 2021).

We noticed poor knowledge of the importance and priority of daily meals, as considerable number of mothers or caregivers give their children incomplete meals. Number of meals is an important factor to ensure children regular growth and development. Skipping meals is associated to undernutrition, anaemia (Petry et al., 2019), and with weight gain (Silva et al., 2017). Incorrect eating behaviours may be related to low level of education of PLW or care givers as well as food shortage, in line with Chamova and Dimitrova (Chamova & Dimitrova, 2020). Apart from food shortage, nutritional disorders found in this study may be associated to cultural issues. Mohseni and Aryankhesal (Mohseni & Aryankhesal, 2020) working also with children under five, concluded that most nutritional problems occur because of inappropriate consumerism associated with cultural habits and prevalence of food-related myths. Women in the resettlement centres wean their children before the recommended period by the WHO, which may contribute to early introduction of new food items. It is recommended that introduction of new foods should be at six months of age (Carneiro et al., 2015), and only exceptionally at four or five months, followed by appropriate care in their handling to prevent infection in infants (Silva et al., 2019), cited as one of causes of secondary malnutrition. In line with what was found in this study, the AVASAN report (SETSAN, 2019) points out that individuals mostly affected by malnutrition are aged 6-59 months. Non-compliance with exclusive and non-exclusive breastfeeding may also be related to poor health education of women subjects of this study. A similar study carried out by Lima and co-workers (Lima et al., 2018) pointed to mothers' lack of knowledge about the importance of breastfeeding as one of the factors for early weaning.

Populations in resettlement centres have unbalanced food consumption characterized by consumption of cereals and derivatives, fish, legumes and snacks. They consume with very low frequency fruits, horticultural products and milk. Likewise, a study carried out in the peri-urban area of Nampula indicated that population’s food consumption consists of cereals and tubers, and a reasonable intake of minerals (37%) obtained from vegetables, but food is poor of fruit (Zano, 2017). Unbalanced food consumption is the cause of occurrence of nutritional disorders in children and pregnant women (Petry, 2019). The severity of nutritional problems is proportional to the magnitude of food availability. As hunger have increased in 2020 under the shadow of COVID-19, being Africa most affected continent (21%) [WHO, FAO, UNICEF, IFAD, WFP (2021)], urgent actions are needed to tackle the 2030 Sustainable Development Goal towards zero hunger, though still challenging.

CONCLUSION

Overall nutritional status of children under five years of age is normal. However, some were diagnosed with chronic malnutrition, acute malnutrition and low weight for age. There are also cases of overweight and obesity. Pregnant and lactating women were also diagnosed with acute malnutrition. Food consumption in the population is predominantly made up of cereals, legumes, fish, tubers and derivatives, and other food items are consumed with less or moderate frequency. Easily raised or purchased foodstuff were most consumed in population. Finally, a comparison of the two moments (before and after cyclone) revealed that food quality and quantity tended to decrease with cyclone Idai.

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