Literature Review

TEXTO & CONTEXTO ENFERMAGEM
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HEALTH PROMOTION IN CARE FOR PEOPLE WITH CHRONIC NON-TRANSMITABLE DISEASE: INTEGRATIVE REVIEW

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ABSTRACT

Objective: to analyze the health promotion practices developed by nurses in the care of people with non-transmittable chronic disease in primary health care, in scientific publications, between 2007 and 2017.
Method: an integrative literature review of a qualitative approach, conducted in five databases, in which was read and critical analysis of the studies in order to know the practices of health promotion.
Results: 40 articles were selected and organized according to the fields of the Ottawa Charter: public policies, reorientation of health services, creation of personal skills, reinforcement of community action and favorable environments. Thus, most of the experiments were mainly related to two fields of action: development of personal skills and reorientation of the health system. There is a movement towards the development of a health promotion in which the collective, the social determinants of health and multidisciplinarity are advocated.
Conclusion: some limits were identified that need to be overcome, among which stands out the inter-sectoral work that needs to grow beyond the health sector.

DESCRIPTORS: Primary health care. Nursing care. Chronic disease. Nursing. Promoting the health.

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PROMOÇÃO DA SAÚDE NO CUIDADO ÀS PESSOAS COM DOENÇA CRÔNICA NÃO TRANSMISSÍVEL: REVISÃO INTEGRATIVA

RESUMO

Objetivo: analisar as práticas de promoção da saúde desenvolvidas pelos enfermeiros no cuidado às pessoas com doença crônica não transmissível na atenção primária à saúde, em publicações científicas entre de 2007 e 2017.
Método: revisão integrativa de literatura de abordagem qualitativa, realizada em cinco bases de dados, nos quais se fez uma leitura e análise crítica dos estudos de modo a conhecer as práticas de promoção da saúde.
Resultados: foram selecionados 40 artigos, sendo organizados de acordo com os campos da Carta de Ottawa: políticas públicas, reorientação dos serviços de saúde, criação de habilidades pessoais, reforço da ação comunitária e ambientes favoráveis. Dessa forma, a maior parte das experiências estava relacionada principalmente a dois campos de ação: desenvolvimento de habilidades pessoais e reorientação do sistema de saúde. Nota-se um movimento em direção ao desenvolvimento de uma promoção da saúde em que se preconiza o coletivo, os determinantes sociais da saúde e a multidisciplinaridade.
Conclusão: identificaram-se alguns limites que precisam ser transpostos, dentre os quais se destaca o trabalho intersetorial que precisa crescer para além do setor saúde.

DESCRITORES: Atenção primária à saúde. Cuidados de enfermagem. Doença crônica. Enfermagem. Promoção da saúde.

PROMOCIÓN DE LA SALUD EN EL CUIDADO DE PERSONAS CON ENFERMEDADES CRÓNICAS NO TRANSMISIBLES: UNA REVISIÓN INTEGRADORA

RESUMEN

Objetivo: analizar las prácticas de promoción de la salud llevadas a cabo por los enfermeros al cuidar d personas con enfermedades crónicas no transmisible en la atención primaria de la salud, en publicaciones científicas de 2007 a 2017.
Método: revisión integradora de la literatura con enfoque cualitativo realizada en cinco bases de datos, en las que se efectuó una lectura y un análisis crítico de los estudios de modo de conocer las prácticas de promoción de la salud.
Resultados: se seleccionaron 40 artículos y se los organizó de acuerdo con los campos de la Carta de Ottawa: políticas públicas, reorientación de los servicios de salud, desarrollo de habilidades personales, refuerzo de la acción comunitaria y ambientes favorables. De esta manera, la mayor parte de las experiencias se relacionó principalmente con dos campos de acción: desarrollo de habilidades personales y reorientación del sistema de salud. Se nota un desplazamiento en dirección al desarrollo de un enfoque de promoción de salud en el que se promueve lo colectivo, los determinantes sociales de la salud y de la multidisciplinariedad.
Conclusión: se identificaron algunos límites que deben superarse, dentro de los cuales se destaca el trabajo intersectorial que debe extenderse más allá dl sector de la salud.

DESCRIPTORES: Atención primaria de la salud. Cuidados de enfermería. Enfermedad crónica. Enfermería. Promoción de la salud.

INTRODUCTION

Chronic Non-Transmittable Diseases (CNTDs) are considered one of the major health challenges. In 2012, they accounted for 38 million deaths worldwide, projected to be 52 million by 2030, meaning a significant increase in adults diagnosed with CNTDs.[1–3]

CNTD are responsible for a high number of premature deaths, decreased quality of life, high degree of limitation for work and leisure activities, negative impact on the economic issues of families, individuals and society, resulting in worsening social inequalities and poverty.[4] In Brazil, 2007 data show that 72% of deaths were due to these diseases.[5]

Given the current situation, it is necessary to take measures to establish a commitment to address this issue.[4] Considering that the health care of these people needs to be carried out continuously, coordinated and integrally, so that the demands triggered by this situation are minimized.[6] Among the possible measures, one is currently highlighting health promotion.[4] This approach brings political and planning action to the scene and is reinforced as a practice of accountability and health care.[7]

Health promotion has a historical trajectory marked by constant theoretical and conceptual debates.[8] Initially, its traditional concept was elaborated in the 1940s in the Natural History of Disease scheme as one of the elements in the level of attention in preventive medicine.[9]

Over the years, great facts have occurred that contributed to the modification in its concept. One of these was the modern health promotion movement that emerged in Canada in the 1970s with the publication of the "Lalonde Report", the first official document to use this term. Despite its evolution, the focus on lifestyle changes still remains, with an approach to individual action, adopting a behavioral and preventive perspective.[8]

That publication eventually sparked debates, which resulted in the motivation and holding of the First International Conference on Health Promotion (1986), whose product originated the Ottawa Charter. In this document, health promotion was defined as "the process of empowering individuals and the community to improve their quality of life and health, including greater participation in the control of this process"[10:1] and develops through five action fields: Healthy public policies, enabling environment, community action, personal skills, and reorientation of services.[9–10]

These fields of action are considered to be the main frame of reference for health promotion, as recognized and reaffirmed by the other subsequent international conferences.[9]

Given this trajectory, it is possible to realize that health promotion aims at overcoming the biomedical model, but to this end it must be considered as a transformative process capable of improving the living and health conditions of the population.[11] That is, it is essential to intensify health promotion actions and strategies, based on the five Ottawa Charter fields of action, that drive the necessary transformations in the population's health reality, given that these practices are characterized by having a holistic conception, inter-sectoral approach, community empowerment, social participation, pursuit of equity, action on Social Determinants of Health (SDH), and development of multi-strategic and sustainable actions.[12]

The persistence of the theoretical conception of health promotion based on the behavioral model hinders advances towards an emancipatory perspective that contributes to the Unified Health System (*Sistema Único de Saúde*, SUS). Rescuing the SUS principles is to break with the attention that is characterized by the centrality of medical work, focused on the treatment of diseases, as well as hospital activities performed for this purpose. Through this, one seeks to recover the actions of health promotion, prevention and treatment of diseases at different levels of care.[13–14]

The process of implementation of the National Health Promotion Policy (NHPP) in Brazil was a long and complex trajectory, with a preventive focus, but it represented an advance in the elaboration of health policies in defense of SUS that, launched for the first time in 2006, had a transversal, integrated and inter-sectoral character. Despite the advances, many events have designed new scenarios and challenges, resulting in their re-elaboration in 2014.[15] This causes changes in the ways of organizing, planning, performing, analyzing and evaluating health work, bringing in essence the need to establish a relationship with the other public policies already achieved.[13,16]

Among the SUS attention levels for developing health promotion actions, Primary Health Care (PHC), developed with the highest degree of decentralization and capillarity, is highlighted. As one of the main ports of entry and communication with the Health Care Network, PHC becomes and needs to be the user's preferred contact.[17]

In Brazil, PHC develops through the Family Health Strategy (FHS), which has as one of its pillars the structuring of the care model, prioritizing prevention and promotion, without neglecting care.[18] For developing Family Health, PHC has a multidisciplinary team.[17] All professionals are essential for the consolidation of this strategy and the reorganization of the health care model in the country. However, the focus of this research refers to the nurse's performance, which performs educational, care and administrative activities, contributing to the resoluteness in different levels of attention to the population.[19]

Considering the above, the following concern arises: How do nurses develop health promotion practices in the care of people with CNTDs in the PHC, from national and international scientific publications? Therefore, the objective is to analyze the health promotion practices developed by nurses in the care of people with CNTDs in the PHC, in scientific publications, between 2007 and 2017.

METHOD

This is an integrative literature review, a method that allows the synthesis of results from research on a theme in a systematic, orderly and comprehensive manner.[20] A protocol was built to conduct the review, and the following methodological steps were chosen: problem identification; literature survey; critical Evaluation; data analysis and presentation.[21]

The searches took place in the following databases: BDENF, LILACS, PubMed/MEDLINE, SciELO and *Scopus*, in addition to checking the reference list of the articles. A search strategy with Health Sciences Descriptors, *Medical Subject Headings*, was developed for each database, and non-standard keywords, as well as synonyms to cover all publications. The terms were Primary Health Care, Nursing, Family Health Strategy, Chronic Disease, Public Health Practice and Health Promotion (and their English and Spanish correspondents), referenced in the plural and singular terms and with the Boolean terms OR to distinguish them. them and AND to associate them. Table 1 displays the databases searched with the quantity of articles found.

Table 1 – Databases and articles found in absolute numbers. Florianópolis, SC, Brazil. (n=1340)

Databases	Articles
BDENF	51
LILACS	104
SciELO	34
PubMed/MEDLINE	581
Scopus	570
Total	1340

1340 documents were found, whose titles and abstracts were read, using the on-line endnote web® reference manager in order to assist this step. The selection had as inclusion criteria: Journal articles indexed in the chosen databases, in the form of original articles and/or experience reports, which contained the listed descriptors, in the Spanish, English and Portuguese languages, published between 2007 and 2017 and related to the themes Publications of duplicate works were excluded; review articles; Editorials; letters; opinion articles; theoretical reflection; Comments; essays; previous notes; theses; dissertations; course completion works; manuals; abstracts in annals or periodicals; dossiers; official papers; health policies; epidemic bulletins; management reports; books; book chapters and studies that did not address the purpose of this study.

A total of 498 duplicate studies were removed and also 712 because they did not meet the inclusion criteria, resulting in a total of 130 pre-selected studies, which were then subjected to a full analysis of their content. After a critical and thorough reading, 91 articles were excluded because they clearly did not meet the inclusion criteria, resulting in the end of the analysis 39 studies that were included in this review. The analysis of the references was performed in order to verify possible studies that would not have been contemplated in the searches. Thus, an article was listed to be part of this review, as it met the inclusion criteria, thus totaling 40 articles. For the selection of publications the recommendations of the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA), represented in Figure 1.

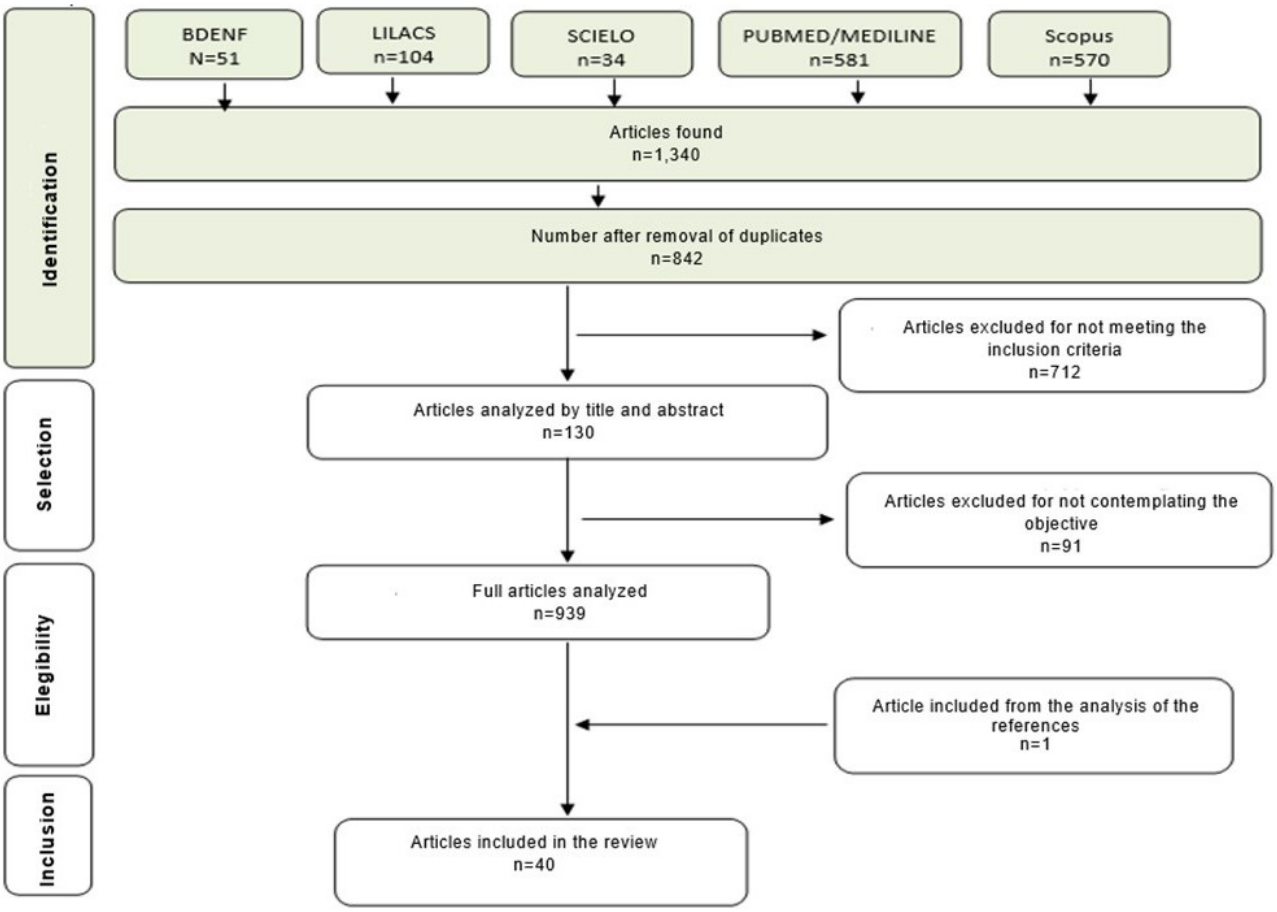

Figure 1 – Study selection process flow for the review

With the complete texts and after exhaustive reading, some results were extracted and transcribed to a data collection instrument, allowing the detailing of the studies.

Finally, a critical analysis of the studies was performed in order to know the health promotion practices. This step followed the methodological steps[21] that were the following: Identification of the study problem; literature survey; critical evaluation of the studies; data analysis; which provided methodological organization and rigor to the study. This review was categorized according to the Ottawa Charter's five fields of action.

After the conclusion of the analysis of each category, a synthesis of the important elements was performed, in order to portray the theme and the review process. Data interpretation took place critically and impartially, in order to allow for presentations of possible explanations for the results found, whether convergent or conflicting, based on the available literature.

RESULTS

The number of studies consisted of 40 articles, 15 published in *Scopus*, 06 in BDENF, five in LILACS, nine in PubMed/MEDLINE and four in SciELO and 01 in the review of references for the selected studies.

The countries of publication that appeared most were: 15 in Brazil, five in Canada and four in the United Kingdom, three in the countries of Spain, Australia, the United States and two in New Zealand, one in each of the following countries, the Netherlands, England, Iceland, Portugal and Thailand. The used methodologies were: In 33, the qualitative research; in four, the quantitative one; and in the remaining 03, the mixed one (qualitative and quantitative). Regarding the year of publication, were: 09 in 2015, seven in 2014, 04 in 2013, 2011, 2008 and 2016 and three in 2012, two in 2017 and one in 2009, 2007 and 2006. The years 2004, 2005 and 2010 had no studies selected for review.

Development and implementation of healthy public policies

One experience found was the Children's Forum. This project is a space for dialog outside the unit, consisting of professionals from different areas who meet periodically to discuss and organize care for children with chronic conditions.[22]

Another report was the work in health facilities in Portugal. In this country, workers are guided by a Basic Service Portfolio. This is a publication issued by the Portuguese Ministry of Health that guides teams on primary health care. Thus, from this document the teams developed their health promotion actions for people with CNTDs in collaboration with other points in the network. Among the actions were observed, clinical follow-up, home care, networking and collaboration with other services and educational activities in groups. It should be noted that in that country there are other services within the PHC that are responsible for educational activities, restricting care actions to health units.[23]

To compare primary care models in health promotion delivery in Canada, a study evaluated seven items that were recommended by the Canadian Task Force. The main measure was whether the user reported discussing health promotion on one of the topics. It was found that the likelihood of one of the issues being debated, regardless of the reason for the visit, was significantly higher in the community-based primary care model. This model gives relevance to health promotion, emphasizing the well-being, prevention, and incorporation of clinical and SDH-based interventions.[24] Another study conducted in the United States reinforces a health model that is proactive, empowered, and competent in promoting health for all population groups.[25]

Finally there is the *Care Plus* from New Zealand. This is a program whose initiative is to provide care for people with chronic disease. It provides funding for additional outpatient care for these people to improve care management, teamwork in PHC and reduction of health inequalities.[26]

Strengthening the community action

In this field, an important point is the participation of people with CNTD in social groups. These constitute a support network, in particular religious movements, and community associations, as people's behavior is influenced by the beliefs and values apprehended in this context.[27–28] It is identified that nurses perform health promotion practices in people with CNTDs, especially in elderly groups, in the community.[28]

In an experience report, it was observed the use of health resources in the coverage area, which were of interest to obtain a favorable outcome for the person with a CNTD. A literacy course was offered in the community library to enable alphanumeric education and to promote care for a better quality of life for these users.[29]

The forums were held with the community to encourage the reduction of alcohol consumption. This action opened opportunities for people to talk about their situation, develop and establish guidelines for working with other problems together in the community.[30]

The importance of working with people with CNTDs in their own homes in the context of their daily lives was also emphasized. Promote a look at the health model focusing on social determinants, being the nurse an essential professional in the multidisciplinary team to develop self-care, the empowerment of these people.[31–32]

Development of personal abilities

The activities developed by nurses are mainly focused on educational practices. Emphasis is placed on guidelines that can improve people's knowledge of their health condition, those related to lifestyle changes, healthy eating, and exercise.[22–23,28,33–46] It is emphasized that educational actions when mediated by words such as adherence and sustained by interactions between these people and professionals are fundamental and increase health care.[34]

Studies show educational practices directed to a collective approach. The group meetings were developed through open dialog and qualified listening, allowing the creation of a free space for the exchange of information and experiences, expanding the horizon of knowledge.[36,47–51] In addition to the use of technologies during group educational activities, such as: Games, dynamics, conversation wheels, audio-visual material, posters, illustrations and informational pamphlets.[27,36,40,52]

One highlights the use of the educational games technique in the activities of the Hypertension and Diabetes Program - HIPERDIA. In addition to the possibility of promoting autonomy, linking the person to the service and expanding the knowledge about their health and disease process, thus contributing to changes in self-care habits.[51] When they discover that they have a health and disease situation and become aware, they assume the identity of the situation, they become proactive in their health care. They also emphasize that a motivational interview, during health education actions, promotes the lives of people with CNTD , towards a healthy lifestyle.[52–53]

Another field found was home visits as an opportunity for health promotion practices through educational actions. These home visits make it possible to know the realities *in loco*, make it possible to distinguish people's living conditions, thereby planning and developing actions in a broader way, taking into account SDH. In addition, these places admit that education is also directed to caregivers, which makes people with CNTD and their families feel safer, favoring the stimulation of accountability for care in coping with CNTDs.[22–23,27,42,50]

Reorientation of the health system

Several studies have highlighted the importance of providing the development of trust and respect for a good therapeutic relationship between user and professional.[27,29,35,50]

Nursing consultations and social groups sought a holistic view of the user, centered on the person, their empowerment, self-care and listening, besides being permeated by longitudinal care. They encouraged dialog and the expression of demands, emphasized approaches that assessed the clinical situation, social environment and psychological condition, from the history of life, health and disease, the doing of these professionals sought the coordination of care.[26,30,33,35,38,50,54–55]

Home visits are seen as an instrument that aims to bring health closer to families, breaking with the biomedical model. They also consider the conditions of the environment, so it was possible to identify the factors that influence the quality of life and contextualize their problems with the determinants of the health/disease process, establishing promotion measures for people, their families and community.[50,54]

The family has a strategic role in Canada, where home-based nurses provided training, where family empowerment was provided, providing them with information about the disease and care.[56–58]

An alternative identified for care was case management. This mode of action allowed users to feel more supported, especially by nurses, as it was their preferred contact because they felt their needs were taken into consideration and because they participated in preparing their care plan.[59–61]

An important point in this field of action is that the work of nurses is articulated with the FHS team and the Family Health Support Center.[27,36] The approach of a multidisciplinary team needs to provide integrative and empowering care, so it is important that care actions are aligned and cohesive, because the work of each professional complements that of the other.[22,26,38,50]

Some studies point out that the needs of these people often exceed the resources available in the health unit, so referrals to other points in the network are needed.[22–23]

DISCUSSION

Almost all articles were found in the *Scopus* database. This relationship may be associated with the fact that this database is one of the largest in peer-reviewed abstracts and citations.[62]

It has been identified that the number of publications on the theme has decreased, which is a concern, after all the CNTDs have drawn attention for their severity.[63]

Regarding the methodological approach, the qualitative research showed a higher incidence. This method allows practitioners to broaden their view of the health/disease process, taking into account other analyzes, such as macroeconomic and historical-cultural.[64]

With the largest number of publications, the country that stands out is Brazil. This prevalence may be related, despite numerous conflicts and late origin, to the creation and redefinition of the NHPP; which provides opportunity for scientific research.[15] Another point refers to the use of the descriptor, Family Health Strategy, which corresponds to the ordering center of the Brazilian SUS health care network.[17]

The commitment to health promotion in Brazil is SUS ethical commitment to integrality and participative management. It is urgent to build levels of attention and coordination of public health policies that operate inseparably between clinic and promotion and between social needs and state actions.[13]

The practice of health promotion was initially understood as preventive actions that prevent the onset, development or aggravation of the disease. While this view persists, driven by the Ottawa Charter, health promotion has expanded to include community-building and collective empowerment activities.[65]

Health promotion aims to overcome the biomedical model by using the fields of action proposed by the Ottawa Charter.[11] These fields constitute a possibility to reinforce broader ways of intervening in health, focusing on the aspects of SDH.[7] Thus, when these practices are inserted in the work process of PHC teams, new forms of care production are provided.[8]

According to the Ottawa Charter, the field of developing and implementing healthy public policies demonstrates that health promotion goes beyond health care, and places it on the priority agenda of politicians and leaders. This action aims to combine the different complementary approaches that, in a coordinated way, point out to the health equity. Thus, inter-sectoriality has proved to be a public sector responsibility for the development of this axis.[10]

However, it is noteworthy that the experiences, despite bringing out the presence of public policies for health promotion, did not address the issue of inter-sectoriality, that is, they were restricted to the health sector. This is unfavorable because articulated action involving various sectors is essential for the success of health promotion actions.[4] There are still major challenges to guaranteeing citizenship rights and improving the quality of life and health of populations, and the evidence points to benefits for inter-sectoral public policies in response to complex issues such as the CNTD.[4] Integrality needs to be advanced to mobilize and make addressing the CNTDs a cross-cutting theme in the process of organizing services and health in general.[66]

The center of strengthening community action is the more empowerment of the communities. The promotion works through concrete and effective community actions in the development of priorities, decision making, strategy definition and implementation, in order to improve health conditions. Community empowerment is developed through the community's own human and material resources to enhance social support, to develop flexible systems and to strengthen popular participation in the direction of health.[10]

For this field of action, the experiences found approach this theme very subtly. This is not a favorable finding because providing community-based health promotion interventions in families and individuals can help reduce the burden of disease.[8] This field of action was the theme of the fourth health promotion conference held in Jakarta (1997), which reveals that promotion should be developed in conjunction with the population, giving them the right to voice, greater access to the process of decision-making. decision making, developing their skills and enabling the knowledge they need to make the changes for a better quality of life.[67]

The field of action with the most studies was the development of personal skills. According to the Ottawa Charter, promotion rests on personal and social development through health outreach, information and education, and enhancing vital skills. Thus, more options are available for the population to be able to exercise greater control over their own health and the environment, as well as to develop actions that lead to better health. To do this, it is necessary to enable people to learn throughout all their lives, it is the advance in the concept of individual empowerment.[10]

Within this field, educational practices were the most prevalent, and their development was observed in both individual and collective approaches, as well as home visits. Health education is an important action of the work of nurses and the FHS team. It allows the construction of a work that values the human being, besides the biological question, which seeks the social, emotional and spiritual side.[65]

Among the individual actions, nursing consultations and home visits stand out. Consultations performed in community practice are considered an essential element in health care for people with CNTDs, provided that they are carried out individually and participatively, providing conditions for improving people's quality of life and, consequently, their health situation.[66]

Regarding activities of collective scope, they are characterized by groups. These are spaces in which health promotion actions can take place, since there is the possibility of providing broadening of the individual's understanding of their health/disease process, and thus favoring changes in lifestyle habits.[67] This practice also contributes to the development of interdisciplinary and cooperative interventions that continually seek to change people's living conditions.[68]

The relationship between user and nurse identified is based on attachment and autonomy. This differentiated look favors the verbalization of everyday aspects, creating a space of reciprocity between them.[26] Finally, nurses can contribute to a change in the relationship between professionals and the community by encouraging health promotion actions and by valuing partnerships rather than individual and paternalistic approaches.[69]

The theme addressed in educational actions was mainly related to lifestyle changes. The CNTD requires follow-up in PHC, as it requires changes in people's habits and behavior, which is a challenge for the service, however, should not be the sole focus of educational activities, but should be encouraged individual and collective strengthening.[70] In this regard, action on health promotion is directed toward community engagement in order to provide collective decision-making, and even to influence policy decisions that directly affect a community and can modify the SDH.[71]

Educational work should include dialogue with people about possible ways of taking care of their health, understanding the causes and consequences of their state.[72] Thus, it would be interesting for professionals to stimulate the awakening of the autonomy of people with CNTDs, in order to be able to help develop knowledge, skills, attitudes and self-knowledge, so as to take responsibility for their decisions about their health. That is, what you want is not to control the disease, but to help manage life despite the disease. Therefore, it is necessary to know people closely, their life context, their potentiality and adversity, so that it is possible to maintain a relationship between professional and population that encourages empowerment.[73]

With this differentiated look it is possible to work with people with CNTDs and not for them, showing them mechanisms that go beyond the prescription for treating their health condition. It is necessary to work on actions that go against the biomedical paradigm still prevailing in professional practice, which overestimates the curative aspect, and no longer responds to the effective needs of people with CNTDs.[66]

The reorientation of the health system means that promotion is the responsibility of health services, shared with individuals, communities, groups and institutions, that is, all working together to reproduce a health system that contributes to a high level of health.[10] PHC is a strategic axis for the development of health promotion, as it focuses on the comprehensiveness of actions and care from a broader perspective, valuing the socio-political context of the environment in which people live.[13]

This axis represents the adoption of a new logic in the work process.[11] The nurse, in turn, has contributed to its development, as observed in the experiences presented. The user-centered approach and empowerment help them gain skills and knowledge about managing their health status, increasing satisfaction and adherence to care.[74]

The field of action and creation of favorable environments was the only one that did not submit studies that contemplated its concept. Understood as the protection of the environment and the monitoring of the changes that it reproduces in health, recognizes the complexity of societies and interdependent relationships between different sectors, making it understand that health cannot be separated from other goals and objectives.[10] This lack of experiences of the nurses in PHC field, for people with CNTDs, gives rise to a warning signal that health promotion practices that encompass the field of favorable environments need to be encouraged. Looking at the environment can awaken a broader view of the health/disease process of the communities, and go against the biomedical model, which can no longer meet the needs of this public of the CNTDs.

Regarding the limitations of the study, we highlight the large number of national publications, and this may be related to the choice of the descriptor Family Health Strategy, which directed the search in the Brazilian scenario. In addition to this limitation, it is necessary that health professionals incorporate into their daily actions inter-sectoral actions that promote changes in the living conditions of people with CNTDs. As a positive point, the possibility of further studies on the same theme with CNTDs in other scenarios of health care networks is emphasized.

CONCLUSION

At the end of this review, it is believed to have achieved the proposed objective, which aimed to analyze the health promotion practices developed by nurses in the care of people with CNTDs in the PHC. From the found studies, it was noted that most health promotion practices were mainly related to two fields of action from the Ottawa Charter: reorientating the health system and developing personal skills.

In the first axis the studies showed that nurses sought to develop a praxis in a new logic, which prioritized longitudinal care, centered on the person and the SDH, but with little inter-sectoral articulation. On the other hand, in the second field, the focus was on individual empowerment, through the educational practices in which autonomy and self-care were stimulated, however the actions were still much directed towards a healthy lifestyle, going against health-related promotion.

The other two fields, healthy public policy-making and reinforcement of community action, submitted studies, but with fewer and subtle characteristics. Finally, the creation of favorable environments did not show studies in this area, which is a worrying sign, since it is known how much the environment influences the quality of life and health promotion of people with CNTDs and how much these pathologies have been gaining importance, due to the large number of cases.

It is noteworthy that with the health promotion practices developed by nurses, people with CNTDs are gaining ground in the scenario of this professional, in addition, there is also a movement toward the development of a health promotion in which advocates collective, SDH and multidisciplinary work. However, at the same time as these advances happen, some weaknesses still need to be addressed, among which stand out the inter-sectoral work that needs to grow beyond the health sector, as well as the creation of favorable environments for this specific population.

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NOTES

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CONFLICT OF INTERESTS

There is no conflict of interest.

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