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Representations regarding the rational use of medications in Family Health Strategy teams

REPRESENTAÇÕES SOBRE USO RACIONAL DE MEDICAMENTOS EM EQUIPES DA ESTRATÉGIA SAÚDE DA FAMÍLIA

REPRESENTACIONES SOBRE EL USO RACIONAL DE MEDICAMENTOS EN EQUIPOS DE ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

This qualitative, descriptive and exploratory study was performed with the objective to identify and understand the representations regarding the rational use of medications in three Family Health Strategy (FHS) teams in the urban region of Dourados, MS, founded on the theoretical framework of Stuart Hall's concept of representations. The chosen methodology was the focal group technique and the data were evaluated using thematic content analysis. There were a total of 26 participants. The professionals highlighted the curative role and the negative aspects of medications. They also presented representations regarding their patients, reporting that they do not understand the correct use of the medications, do not comply with the recommended treatment and engage in self-medication. There is a need to implement educational health practices to promote the rational use of medications.

DESCRIPTORS

Drug utilization
Culture
Primary Health Care
Family health
Health education
Family nursing

RESUMO

Pesquisa qualitativa, descritiva e exploratória, cujo objetivo foi conhecer e compreender as representações sobre o uso racional de medicamentos em três equipes da Estratégia Saúde da Família (ESF) da zona urbana do município de Dourados-MS, tendo como aporte teórico o conceito de representações de Stuart Hall. Como técnica utilizaram-se os grupos focais, e a avaliação de dados deu-se a partir da análise temática, modalidade da análise de conteúdo. Participaram da pesquisa 26 componentes. Verificou-se que os profissionais destacaram papel curativo e aspectos negativos dos medicamentos. Também apresentaram representações acerca dos pacientes, relatando que não compreendem o uso correto dos medicamentos, não aderem ao tratamento e se automedicam. Nota-se a necessidade de implantação de práticas educativas em saúde para promoção do uso racional de medicamentos.

DESCRIPTORES

Uso de medicamentos
Cultura
Atenção Primária à Saúde
Saúde da família
Educação em saúde
Enfermagem familiar

RESUMEN

Investigación cualitativa, descriptiva y exploratoria, cuyo objeto fue conocer y comprender las representaciones sobre el uso racional de medicamentos en tres equipos de la Estrategia Salud de la Familia (ESF) de la zona urbana del municipio de Dourados-MS, teniendo como aporte teórico el concepto de representaciones de Stuart Hall. Como técnica, se utilizaron los grupos focales y la evaluación de datos se produjo mediante análisis temático, modalidad de análisis de contenido. Participaron de la investigación 26 individuos. Se verificó que los profesionales descartaron el papel curativo y aspectos negativos de los medicamentos. También expresaron representaciones acerca de los pacientes, relatando que no comprenden el uso correcto de los medicamentos, no adhieren a los tratamientos y se automedican. Se demuestra la necesidad de implantación de prácticas educativas en salud, para la promoción del uso racional de medicamentos.

DESCRIPTORES

Utilización de medicamentos
Cultura
Atención Primaria de Salud
Salud de la familia
Educación en salud
Enfermería de la familia

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INTRODUCTION

In 1985, at a conference held in Nairobi, Kenia, the World Health Organization (WHO) established that rational use of medicines (RUM) requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community⁽¹⁾.

On the opposite, the multiplicity of pharmaceutical products available, patients' compulsive medication intake, which is one of the strains on the need for medication prescriptions, drugs propaganda in the media, easy medication access on the internet and health professionals' education, who privilege curative actions to the detriment of health prevention and promotion strategies, among other factors, can contribute to the bad use of medicines⁽²⁾.

The National Health Surveillance Agency (ANVISA) presents data that reveal the dimensions of irrational medication use, affirming that 15% of the global population consumes more than 90% of pharmaceutical production; 50% of all drugs are prescribed, distributed or used irrationally; hospitals spend between 15% and 20% of their budgets to treat problems deriving from bad medication use; and 40% of patients who visit emergency services due to intoxication are victims of medicines⁽³⁾.

It is known, however, that medication use is not a mere therapeutic practice based on the biomedical model. The act of taking medication involves much more than the physical intake of pharmaceutical substances for therapeutic goals. Each drug combines different elements, including scientific practices, political agendas, commercial interests, besides other social and media components. Medicines are not just chemical compounds, but cultural entities. They are products of human culture, but also produce culture, affecting the representations of life and society⁽⁴⁾.

In that context, when discussing medication use, its cultural and social dimensions need to be taken into account, as well as its anthropologic nature, considering that medicines comprise several dimensions, loaded with senses and meanings in singular contexts and situations⁽⁵⁾.

Hence, studies on human beings' experiences in daily medicine use and the representations deriving from these experiences can contribute to understand this phenomenon, which is medication use. These representations are historically constructed and woven in singular contexts, involved in sometimes positive and sometimes negative meanings, and thus produce identities⁽⁶⁾.

In a metanalysis of research on the meanings of medication use for patients, only issues related to non-adherence to treatment were focused on, but the results found reflect some degree of fragmentation, due to heterogeneous methodologies and further dialogue with the theoretical approaches used⁽⁷⁾. Therefore, further qualitative research is needed, looking at patients and health professionals' perspective, enhancing the understanding of this phenomenon, which is medication use.

Thus, the aim in this study is to get to know and understand representations on the rational use of medicines in Family Health Strategy teams active in the urban region of Dourados, MS, Brazil.

METHOD

A qualitative, descriptive and exploratory research was developed in the primary care network of Dourados, a city in the state of Mato Grosso do Sul, Brazil. With a territory of 4,086.244 m², this city is located at 214 km from Campo Grande, the state capital. According to data by the Brazilian Institute of Geography and Statistics, in 2010, the estimated population corresponded to 196,035 inhabitants, with a demographic density of 47.97 inhab/km²⁽⁸⁾.

The Municipal Health Secretary in the city indicated three FHS to develop the study. These teams are located in a neighborhood called Izidro Pedroso and are part of the city's urban primary care network, which during the study period comprised 39 FHS, five health centers and one clinic⁽⁹⁾. All team members were invited, totaling 39 professionals, including: community health agents, nursing assistants, nurses, physicians, dentists, dental aids and receptionists. Some team members were unable to attend the scheduled research meetings though, and therefore did not participate in the research.

A facilitator applied the focus group technique with the help of a pre-planned script, which permitted the organization of the participants' discourse and the inclusion of all in the discussion⁽¹⁰⁾. In this study, three groups were organized, one from each Family Health Strategy team, on three different days. Besides the facilitator, each group consisted of two reporters, who immediately transcribed the participants' discourse. The facilitator launched the following guiding questions: *Talk about your experiences with medicines in your life; Talk about medication use in your daily professional life*. Thematic content analysis was used to evaluate the interviews⁽¹⁰⁾.

Stuart Hall's concept of representations served as the theoretical framework for this study. In this concept, language functions through representation, i.e. meanings have actual effects and regulate social practices. The

...studies on human beings' experiences in daily medicine use and the representations deriving from these experiences can contribute to understand this phenomenon, which is medication use.

acknowledgement of these meanings contributes to the constitution of identities and calls on us to take positions that are constructed in discourse practices. Thus, the productive nature of language is articulated with the notion of representation, and language is used to produce meanings. Representation involves signification practices through which these meanings make it possible to understand experiences of life, which are specific to singular historical places and times⁽¹¹⁾.

Representation practices connect meaning and language to culture. Representing means using language to say something specific or represent the world in a way that is significant to others. Representation is a fundamental part of the process through which meaning is produced and shared among group members. In other words, representations derive not only from how something is used, but also from what is said, perceived and integrated in daily practices⁽¹¹⁾.

The research proposal was submitted to the Committee for Research involving Human Beings at *Universidade Federal de Mato Grosso do Sul*, and received approval under protocol 1801/2010. This study is linked to the Project *Health Education Practices to Promote Rational Use of Medicines in hypertensive and diabetic patients in the primary care network*. The interviewees were invited to participate in the research voluntarily and signed an informed consent term. To preserve the interviewees' anonymity, the following codes were attributed: P1.A, P1.B, P1.C, with A, B and C referring to the FHS the interviewee was affiliated with.

RESULTS

Study participants were 26 FHS members, nine from FHS A, seven from FHS B and ten from FHS C. In terms of professional category, three were nurses, three physicians, one dentist, four nurse assistants, one dental aid, 12 community health agents and two receptionists. Among the predominant sample characteristics, it was verified that most were women, with 20 participants. The participants' mean age was approximately 39 years and, on average, they had been active in the FHS for about five years. As for education, 15 had finished secondary education, nine higher education, one had not finished higher education and one had not finished primary education.

Based on the focus groups held at FHS A, B and C, the following analytic categories emerged: FHS professionals and medicine use, patients and medicine use.

FHS professionals and medicine use

In their statements, the professionals demonstrated the meanings they attribute to the medicines. These meanings are representation practices on medicine use through language. For these subjects, the medicines represent objects to cure diseases, which should only be used

upon a medical prescription. In this case, the biomedical model seems to be the base for these professionals' explanations.

...If it's hurting, that's it. Let's go to the service. The doctor will indicate what medicine he'll have to take (P1.A).

In addition, based on the professionals' reports, negative representations emerged that were attributed to the medicines. These representations are associated with these subjects' experiences of the side effects or damage caused by inadequate use, like self-medication for example. In this respect, the professionals demonstrated the perception that medicines are not harmful. According to them, that distinguishes them from the *lay* population, who sometimes seems to consume medicines exaggeratedly to gain immediate relief for their problems, however, without considering the risks of this attitude.

My experience was with medicine to lose weight. I gained everything I had lost. It also changed my behavior, I got irritated, weepy and 'electric', I had a lot of energy (P4.C).

I've got a traumatic experience. I used to work at a pharmacy when I was a child; then we ran out of candy and I ate a lot of pediatric Melhoral®. I ended up in hospital on an overdose of Melhoral® (P2.C).

My experience involved fluoxetine. I used to work at two hospitals; then they told me that fluoxetine was good to stay awake. I took it and stayed awake for three days (P3.C).

Patients and medication use

The professionals' reports on patients and their medicine use express that they do not understand information about the use and, often, due to lack of knowledge, they end up using drugs irrationally, exposing them to severe risks.

Patients also experience difficulties to understand the medical prescription. In one case, there was a patient who'd have to take three anti-inflammatory pills at eight o'clock but took three every eight hours. There are cases of allergic reactions to dipyrone, extrapyramidal reactions to metoclopramide (P4.B).

There's a problem when patients mix up prescriptions. They also visit many doctors in different specialties and each prescribes a new treatment without knowing the previous one, and patients do not inform that they're already using other medicines (P5.C).

Patients also face great difficulty to understand the medical prescription. Sometimes, there's a drug they have to take every eight hours and they take it at eight in the morning and eight at night (P5.C).

...Sometimes the person is accustomed to Capoten® but we take captopril, and then we face difficulties to convince the patient that it's the same drug he was taking. Mainly elderly patients, it's difficult to convince them (P2.A).

The Family Health Strategy teams under analysis, however, still face difficulties to put in practice rational medicine usage promotion strategies and seem to remain restricted to isolated user orientation practices, sometimes merely giving advice and warning on the harmful effects of these therapeutic resources and the importance of adhering to treatment and not adopting self-medication:

Often patients also take a drug because the neighbor takes it and it works. Sometimes he discovers that he's hypertensive and wants to take captopril because the other person takes it and it works. But I always say that it's no use to take the medicine another person takes because organisms differ from person to person. Now that behavior has decreased in the patients because I tell them and they're afraid of taking a drug without a doctor's order (P8.C).

There was a person in my area who was hypertensive and diabetic. And he used to take the medicines until Thursday morning. Then he drank Thursday night, Friday, Saturday and Sunday. And, although the nurse visited and advised him, he didn't change his habit (P2.A).

Besides the mentioned representations, the professionals describe patients' practices that go against the rational use of medicines, among which self-medication and non-adherence to treatment stand out. According to the professionals, these conducts can be interpreted as rebellion and lack of interest in achieving a better health status, perhaps discouraging the team to develop rational medicine use promotion interventions.

There are cases of hypertensive patients who do not take medication, they just go to the health service when they have a crisis (P5.B).

Regarding the patients, I see that they often abandon treatment. They often drink teas instead of taking the medicines (P1.C).

Besides self-medication and low levels of treatment adherence, the professionals reported that some patients act as medicine *prescribers and dispensers*, indicating and distributing medication in their social networks. These practices represent considerable challenges to the health team, besides the risk of inadequate medication use.

Patients take a lot of medicines prescribed by the neighbors. There's one patient who was always asking prescriptions for dipyrone, diclofenac, amoxicillin because she was always medicating the neighbors. Now we are achieving changes, but she's a complicated person because whatever medicine she's got at home she takes and gives to her children (P7.B).

There was a patient who arrived at the reception desperate and full of bumps (cutaneous eruptions). Because he took a medicine another person had indicated (P1.B).

DISCUSSION

Considering the community health agents, the FHS teams' characteristics converge with a study developed in Ribeirão Preto, which focused on these professionals' rational use of medicines. In that study, the agents' mean age was 39 years, most of them were women and had finished secondary education⁽¹²⁾.

As for the FHS professionals' representations, the curative role of medicines still seems relevant, to the detriment of their prophylactic and palliative functions, which were less considered. This can prove the predominance of conceptions based on the biological dimension of health and illness. In this perspective, medicines have been the main therapeutic resource, mainly after World War Two, when industrial drugs advanced and means were discovered to prove the efficacy and safety of drugs. Today, medicine use is a phenomenon linked with and subordinated not only to health issues, but also to economic and political aspects. Therefore, medicines can often take the form of goods and therapeutic objects simultaneously⁽¹³⁾.

As a therapeutic resource, the use of medicines is biased, related to its efficacy and intrinsic curative qualities, as an object of relief, reinforcing its popularity and pharmacological optimism. On the other hand, negative experiences resulting from its use reinforce the skepticism surrounding this therapeutic artifact, as well as its representations as an odd, unnatural object that is permeated with secondary effects⁽¹⁴⁻¹⁵⁾.

The health professionals' discourse reinforces the importance of getting to know their experiences with medication use, focusing on the meanings attributed, which can influence their actions in daily health practices, i.e. how the care process for patients who use medicines takes place, mainly discovering conducts towards suspected adverse reactions. A study involving FHS professionals in the state of Ceará found that interventions related to adverse reactions are scarce and that the notification of problems deriving from medication use to the National Pharmacovigilance System has been neglected⁽¹⁶⁾.

Thus, to promote the rational use of medicines, it is fundamental for the FHS team, as the entry door to health services in Brazil, to be prepared to act on adverse drug reactions or other negative effects, which can be linked with irrational use. These adverse effects can interfere negatively in adherence to medication therapy and also cause severe health damage, besides increasing public health system spending⁽¹⁶⁾.

Concerning patients and medicine use, the professionals hold them responsible for incorrect use. The concept of rational use of medicines, however, involves not only aspects related to patients' drug conduct. Studies show that irrational medicine usage practices are also related with professionals' own conducts, among which the following can be mentioned: lack of necessary patient orientations, inadequate prescrip-

tions, dependence on commercial and non-scientific information sources on rational use of medicines, non-compliance with recommendations deriving from scientific studies and negligence to notify suspected adverse reactions, including extremely severe ones, to supervisory entities⁽¹⁷⁾. Also, medication prescriptions can be influenced by industrial drugs marketing and by the fact that cultural standards have established representations that, in any and all consultations, medication treatment is almost compulsory⁽¹⁸⁾.

Another fact the health professionals appointed referred to patients' lack of knowledge about correct medication use. Consequently, inadequate practices may exist and users may be exposed to adverse and toxic drug effects. One main possible triggering factor is ineffective communication between health professional and patient⁽¹⁷⁾, as the use of technical terms and complex explanations hampers patients' understanding, and many feel embarrassed to demonstrate their doubts, so that the non-understanding of the therapeutic scheme and the disease itself continue⁽¹⁹⁾.

In a study on schizophrenic patients' medication adherence, although the patients appointed the medication as a relevant strategy in the treatment of this chronic disorder, insufficient knowledge on the medication treatment was observed, like not knowing the name of the drugs taken for example, believing that the medicine will cure this chronic disorder and, hence, that the medicine would only be prescribed for a limited period. Hence, precarious understanding of the disease and treatment can act as barriers in treatment compliance⁽²⁰⁾.

Sometimes, the role of health professionals can simply be to verify medication treatment compliance, as a result of fragmented representations in the care process. In a study about community health agents' activities in the promotion of rational medicine use in Ribeirão Preto, it was verified that these professionals become more vigilant towards medication use, like questioning whether the patient is taking the medication *correctly*, but quite disjointed and distant from an interdisciplinary perspective⁽¹²⁾.

Besides the patients' lack of understanding on medication therapy, health professionals reported on users' difficulties to comply with treatment or promote self-medication. Studies describe that patients' medication treatment adherence is closely related to their understanding about their diseases and treatment. In addition, the absence of symptoms can be a preponderant factor in treatment abandonment. Health professionals can often assume a somewhat hierarchical position, ignoring patients' knowledge, experiences and representations of their disease and treatment. Thus, in the care process, non-contextualized or even insufficient information may be provided about patients' health status and particularities of the proposed treatment, thus making their adherence more difficult^(17,19).

Non-adherence to treatment, on the other hand, also involves patients' desire to keep control over themselves, especially in chronic treatments, in which they gain some

knowledge about the medicines and learn to decipher effects and reactions the drugs provoke⁽⁶⁾. Hence, sporadically forgetting to use the medicines and self-medication overlap the prescriptions and may even mean autonomy to these patients⁽²¹⁾. For health professionals, however, not complying with or questioning prescriptions is considered a resistance strategy⁽⁶⁾.

This reveals the importance of interdisciplinarity in the promotion of rational medicine use, mainly in the context of the Family Health Strategy⁽¹⁹⁾. The interdisciplinary team needs to work cohesively to elaborate converging and collaborative practices, prioritizing non-medication therapy whenever possible, with a view to demystifying the cultural issue that all evils should be cured through medicines. The health team needs to attempt to understand users' experiences and representations about medication use, so as to adapt to the way of dealing with these people, granting them clear information on their disease, clinical status and the need for and characteristics of the proposed treatment⁽¹⁸⁾.

In this interdisciplinary team, nursing plays a relevant role in the promotion of rational medicine use. In the Family Health context, together with the health team, nurses' paramount function is to develop disease and problem prevention and promote health, in which health education serves as one of its main intervention instruments. These professionals are also responsible for developing permanent education in the nursing team and among community health agents; therefore, nurses' understanding of health team members' representations on rational medicine use permits developing more effective, problem-solving and cooperative practices⁽¹²⁾.

CONCLUSION

Through this study, we verified that the daily work and histories of the health professionals who participated in this research are permeated by drugs-related experiences, which produced mainly negative representations. In their discourse, the professionals reported that medicines are not harmless, as inadequate practices entailed negative consequences, even showing some fear with regard to medication use.

We also found that, although professionals are unable to clearly define the rational use of medicines, they understand what it represents to a certain extent, and many express the importance of following the medication prescription correctly and the risks of self-medication, among other aspects. They express representations, however, that the patient still seems to be the main responsible for rational medicine use, showing that their perceived roles in the promotion of this practice may demand educative actions that arouse reflections and lead to transformations.

We also concluded that the study participants present representations about the other party, in this case the patients' use of medicines and describe that they do not understand medication use information, medicate themselves and do not adhere to treatment. According to

the health professionals, these conducts may indicate patients' resistance. In addition, correct medication use can be hampered by ineffective communication between professionals and patients as, often, insufficient information is provided about their health status and the particularities of the proposed treatment.

It was verified that the rational medicine use promotion strategies the Family Health Strategy professionals formulated remain punctual initiatives with a curative focus, in which

the biomedical worldview prevails. Hence, health education practices on the rational use of medicines need to be formulated, focusing on interdisciplinary team involvement and the inclusion of other professionals, like pharmacists, thus promoting ruptures with the curative and medicine-centered model. Therefore, it is fundamental to know these professionals' representations about the illness process, about medicines and their rational use, knowing the positions these individuals take in their discourse with a view to enabling them to develop more effective care processes.

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