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Educational views and practices of medical and nursing professionals: a descriptive study

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ABSTRACT

Aim: To describe the educational views and practices of family health teams to people with arterial hypertension and their relatives. **Method:** This is a qualitative study performed with 12 medical and nursing professionals from a municipality located in the Brazilian state of Parana. The data was collected in May 2011, with a semi-structured instrument and submitted to the analysis of content. **Results:** The professionals believe that education in health is an action to promote health and prevent diseases, but they have a narrow perspective regarding the disease and the individual, despite the fact they recognize the importance of the family in the process; the views about working conditions and technical-scientific preparedness reinforces this view. **Discussion:** The educational practice must empower families to be able to transform their reality, which does not happen based on reductionist and traditional educational practices. **Conclusion:** These professionals must search for further information that can open their minds regarding educational views and practices, empowering the families to emancipate the care and the control over the illness.

Descriptors: Hypertension; Health Education; Health Personnel; Family Health Program.

INTRODUCTION

Systemic arterial hypertension (SAH) is a multifactorial clinical condition characterized by high and sustained levels of arterial pressure (AP). It is commonly associated with functional and/or structural alterations of the target-organ (heart, brain, kidneys, and blood vessels) and metabolic alterations, as a consequence of the rise of cardiovascular events⁽¹⁻²⁾.

SAH is a relevant public health issue due to its economic and social implications, based on its chronicity and its silent characteristic that impedes the perception of the issue by the subjects who are SAH holders, as well as the fact that it generates early retirement, long periods of hospitalization, high costs of treatment, and changes in self-esteem and self-evaluation of the individual⁽³⁻⁴⁾.

The initiatives in education in health are one tool that health professionals, such as nurses, must adopt in order to achieve an integral care for the individual holder of arterial hypertension. Education in health can generate opportunities of reflection about health, caretaking practices, and changes of habit, which prevent, or at least slow down, the grievances generated by this pathology⁽⁵⁾.

It is fundamental that the area of health bases its educational processes not only in the transmission of historically accumulated knowledge, but that it also works to build understanding and quality of life for all those involved⁽⁶⁾.

Moreover, in the area of Family Health Strategy (FHS), education in health is a practice attributed to all professionals who are part of the team. However, the family as the unit, which FHS sees as the target of all actions, is, however, a reality being built within the system, both by including whole families in the activities undertaken and by considering the family as the focus of educational actions. The

resilience of individual care is a challenge for family health teams, especially when the heart of patient assistance is based in the patient's family who also experiences the disease with the patient.

Therefore, the objective of this study was to describe the educational concept and practice of the educational FHS teams with the people diagnosed with SAH and their relatives.

In this sense, we aimed to understand the concept of education in health from the professionals' standpoint, their views regarding the inclusion of relatives of patients with SAH in educational action, and the professionals' technical-scientific and structural conditions needed to perform such activities, permitting an analysis about the present educational process and aims for new perspectives regarding the problem studied here.

METHOD

This study was performed through field research, with a qualitative approach, characterized as a descriptive study.

The scenario of this study was a city upstate from Paraná, Brazil; more specifically located in the Ivaí River Basin region. The municipality consists of 20,259 inhabitants⁽⁷⁾, assisted in basic care by six FHS teams, placed in six family health units, five of which are assigned to the population located in urban areas and one assigned to rural areas. At the time of data collection, the health units had all their health teams complete, or in other words, they were composed of a doctor, a nurse, a nursing technician or assistant, and five to six health community agents. The municipality covers 100% of all its FHS needs.

The research targeted the professionals working in basic care in the municipality who could fit in the following criteria of inclusion:

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being an undergraduate in medicine or nursing; being part of the FHS team, and; able to provide assistance to people that experience SAH.

The only criterion of exclusion used was not being at work during the period of data collection. The total number of medical and nursing professionals linked to the FHS teams was able to fit into the criteria established, and they all agreed to participate in the study, which totaled 12 professionals that responded to this study.

The instrument used to collect data was a semi-structured questionnaire, self-applicable, with questions that dealt with the educational views and practices used with the relatives of patients diagnosed with SAH, adapted from the study written by Rosso and Collet⁽⁸⁾.

The data collected in May 2011 was submitted to the analysis of content, based on themes, using the following steps: 1) pre-analysis; 2) formulation and reformulation of hypothesis; 3) exploration of materials; 4) treatment of results and interpretations⁽⁹⁾. To differentiate the subjects while preserving their identity, the following codes were used: the letters E and M to identify nurses and doctors, in this order, followed by a number indicating the order the questionnaires were returned.

The ethical aspects involved in the research with human beings, according to the proposals of Resolution 196/96 of the Brazilian National Health Council were respected. The project was analyzed and approved by the Ethics Committee of Maringá State University under Protocol 091/2011. All participants were informed of the objectives of this study and participated after a formalized agreement was completed through the signature of a Free and Clear Consent Agreement. Contact with the professionals occurred after the authorization of the local health department of the city where this study took place.

RESULTS

Characterization of the participants

In this study, 12 professionals participated: six doctors and six nurses. The age group of the doctors varied from 25 to 65-years-old, with an average age of 43-years-old, and the age of the nurses ranged from 23 to 45-years-old, with an average age of 36-years-old. The work experience in FHS varied from five months to 12 years among the doctors, with an average of three years, and from one to nine years among the nurses, with an average of six years. Regarding their educational background, one doctor mentioned being a specialist in Labor Medicine, two were Pediatricians, and two others did not mention their area of specialization. Among the nurses, one reported being a specialist in Health Surveillance, while another two were in Public Health, with an emphasis on FHS.

The analysis of the content of the registers in the research forms permitted the identification of three thematic categories described as the following.

Education in health as an action to promote health and prevent diseases – simplistic and reduced view of educational activities

The registries related to the views of education in health show that, for some professionals, it is part of the context of assistance:

It is a necessary and essential practice that prevents diseases and promotes health. E4

Education in health is the main objective of a family doctor. It is through education that you achieve health. M4

Education in health is you giving attention to each priority group (hypertensive patients, diabetic, pregnant women, and children) with guidelines and follow up. E5

However, some professionals consider education in health as an activity designed for at-risk groups, moving away from the idea of integrality:

Educate the risk population so we won't have future complications. E3

It is the best way to confront the patient exposing the risks he may be facing. M3

The teams perform traditional educational activities aimed at people that experience arterial hypertension, and assume the importance of the relatives

When making reference to the practices of education in health aimed at the hypertensive patient and his relatives, the professionals demonstrate that they are simplified to lectures and home visits:

I am present at meetings and visits. M1

Meetings with lecture. M2

The so-called meetings, directed at people with hypertension and/or diabetes, in practice, are the moments which the professionals check arterial pressure, test blood glucose, run lectures, and deliver the medication:

[...] home visits, monthly meetings with lectures. E3

[...] through lectures, guidance at home and at the Basic Health Unit (BHU) during the delivery of medication. E6

When stimulated to manifest what they think of the inclusion of relatives of patients with SAH in educational activities, it was seen that, at least in theory, the professionals are all favorable:

It is very important, because they participate in all activities of the patient and end up motivating a better quality of life. E2

Really important, because it is the family that defines the actions in and out of home, demanding a position from the one who is ill. M2

However, when questioned about how the inclusion of relatives occur in these activities, it can be seen that only one participant had an opinion who then explicitly affirmed that he does not include the relatives in the educational activities:

We have a group that works out, verifying their arterial pressure before and after the exercises. Once a month, a blood glucose test and breakfast. With the rest of the family, we don't do anything. E5

It is important to highlight that in their comments, the professionals demonstrated that they know the importance of including relatives in educational activities, despite focusing on a view aimed at the treatment and care of the disease:

Family and intimacy help to control the diet and also help the patient to adhere to drug treatment. M6

It is important to bring awareness so there is more collaboration regarding caring and some privations. E4

The family ends up being a means to assist the effectiveness of the treatment. M3

Important, because the family helps in the process of caring for those that know their diagnosis. E3

However, some professionals understood that the inclusion of the family in the educational process is important in order to achieve the objective to educate to health, in a more emancipatory view, as seen in the words of E6:

This inclusion is very important, as we can see the practical results of patients in whose families know a little bit about the pathology. And according to the patients, the relatives can provide adequate support, and then, these patients can have a better quality of life.

The views about work conditions and the technical-scientific preparedness for the educational practices reinforce the traditional view of education in health

In regards to the adequacy of the actual work conditions to develop education in health towards the relatives and patients with SAH, five professionals noted that they consider these conditions as “satisfactory” based on the results reached among the population:

There was a rise in the number of patients that started to understand the pathology, and that adhere to the drug treatment and the practice of other actions to improve their health. E2

The access to the community, the high acceptance of the team by the community. E1

The other six professionals mentioned that the actual conditions of work are “totally satisfactory” to perform educational activities, and they attribute this success to the quality of the relationships, both between the individuals with SAH and between these individuals and the health professionals:

To the relationship with patients in the basic care unit, at their homes and during the monthly meetings. M3

To the team of the Family Health Program (FHP). M4

The good relationship with the hypertensive patients. M5

To the work done by the FHP team. M6

In regards to the technical-scientific preparedness to develop the activities in education in health, nine professionals noted they had “satisfactory” conditions. However, they showed aspects related to the working conditions as interfering factors:

I believe that, with regards to the technical-scientific preparedness to perform the educative activities aimed at the families of people with SAH, I have enough, but I lack time, as the nurse has too many roles. These educational activities are usually done at the home of the family involved. M4

I assume that my answer is linked to the fact that there is a necessity to

have a set, which means, a doctor with his knowledge, and a patient ready to accept treatment. The largest problem is to have patients accept the treatment. E4

However, three other professionals consider their conditions for performing these activities to be “totally unsatisfactory”:

There should be a higher incentive to make professionals in the area keep studying and then, to have more arguments to convince the community. M2

To improve the working conditions of professionals and to increase the promotion of continued education of these professionals. M1

The lack of capacitation of health professionals, independently from the position the person has. M3

DISCUSSION

We can infer that the interviewed professionals conceive education in health as an objective to be achieved, in order to make the population more responsible for their own health, either in promoting health, preventing diseases, or controlling illnesses. Thus, it is considered that the concept of education manifested by the interviewees of this study was restricted to the importance of the educational practice seen as an activity that anticipates and prevents diseases. This can demonstrate the lack of a broader view of education in health that, in a more complex perspective, is one of the resources in which the human being can exercise citizenship and

achieve personal plenitude, especially in a world where health and quality of life became relevant parts in building the “self” of the individual⁽⁹⁾.

Considering that the educative activities are listed in the Brazilian National Policy in Basic Care as an inherent part of the work process of health teams, it is necessary to rethink the relationship between integrality of care and, in particular, the areas of prevention, promotion, maintenance, and recuperation of health.

Integrality is understood as the overcoming of the dichotomy between the preventive and the curative, besides guaranteeing the accessibility of the citizen to all levels of complexity of existing health services/actions, in an organized and integrated interinstitutional relationship. Thus, in accordance with the views of the professionals, the approach of the health professional should not be restricted to curative assistance, but it should also have the dimension of the factors that influence the risks to life, and, as a consequence, perform emancipatory actions, which also include education in health⁽⁸⁾, leading people to become free and autonomous to make their own decisions.

According to the principle of integrality, the educational activities are included among the responsibilities of FHS professionals⁽¹⁰⁾. Hence, the professionals themselves need to recognize this specificity of their work, filling their practice with an ideology based on the compromise with life, and not only with the prevention of a disease or a possible complication.

When providing a healthcare service based on integrality, the patient with SAH must be cared for as a whole, with special attention paid to the particular conditions of this illness, such as nutrition guidance based on personal necessities and possibilities, as well as ensuring a focus on the place of living and the family space.

In the words of E5, E3, and M3, it can be observed that a concept of education in he-

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alth with activities is aimed exclusively at risk groups. Conversely, healthcare must be holistic, including biological, psychological, and social dimensions of the whole population, not only to those exposed to the risk of falling ill and dying.

The professionals and the service network must articulate the guarantee of offering interventions in the promotion of health, prevention of diseases, cure and control of grievances, and rehabilitation of the ill, with a prioritization of the promotion of health so as to permit the focus on life and not on the illness. The hierarchical network of services must offer the use of technology in the many levels of complexity according to the needs of the users. In a political dimension, the government and society must articulate with one another to create policies that promote health in a more inclusive approach rather than utilizing policies that privilege the prevention of any worsening⁽¹¹⁾.

In this scenario, it is clearly important to articulate the actions in education in health as an element that produces a collective understanding that is translated in the individual into his own autonomy and emancipation to take care of the self, of the family, and of the surroundings, rebuilding the fragmented and disarticulated actions in health⁽⁹⁾. It is necessary to overcome the traditional idea of education in health so the professionals can work with the attention focused on health, not on disease.

The testimonies of E3 and M3 represent the actions of education in health that still aim to prevent infirmities, centering the educational approach on the changes of individual behavior⁽¹²⁾. We can see that there is a change in the concept of education in health that should be anchored in the precepts of health promotion, and not only related to the risk of falling ill⁽⁶⁾.

An observation must be made regarding the possibility of a blaming educational practice when education in health is understood, by the

professionals, as a responsibility of the population, as has been identified in this research. In these cases, the professional usually believes he is socially invested with authority over the area of health and believes he has the monopoly of the true and absolute understanding regarding all topics related to health and illness. Therefore, based on the higher interests of the collectivity, the type of behavior the individuals must assume is imposed⁽⁶⁾.

The majority of the interviewees affirmed that all professionals perform education in health. This type of answer can explain why there is not an effective use of educational activities among the population, because it is linked to the necessity of the professionals to remodel their understandings regarding education in health. This happens because, based on this model of perception, they run the risk of summarizing the educational actions in simple information about health, transferring to the subjects the responsibility to change their behavior, and ignoring the existence of important intervenient factors, such as socioeconomic and cultural conditions that create difficulties in the patient exercising their individual autonomy⁽⁶⁾.

It was seen that the practice in education in health is simplified in lectures and home visits with guidance. These actions are seen in a traditional model of education in health, characterized mainly by the attempt to change individual behavior. With this objective in sight, an educational enterprise is implemented, in which the educator is the holder of knowledge, and the learner—the subject of the educational action—is someone who will passively learn the lessons taught⁽¹²⁾.

However, it is seen that people must participate in caretaking actively, learning to interact with each other, with the organizations, with the health professionals, and the environment. The professional caretaking needs to be directed to

permit opportunities for this learning⁽¹⁰⁾. Thus, the visits must occur in a way to represent a real instrument of approximation between health professionals and the families—in order to learn from the relatives the context and the lifestyle of the individual, and not only as another form of clinical care in the home of the individual⁽¹³⁾.

The presence of an individual with diagnosed hypertension changes the whole family dynamic, especially dietary habits. The family must be a safe and supporting place for the hypertensive patient, in order to motivate him to adhere to the therapeutic recommendations, such as the pharmacological and the non-pharmacological ones, and, especially, to understand that the disease does not change the patient's human condition, it only generates a new way of living.

It is interesting to see that in the view of these professionals of FHS, the family is a facilitating factor of assistance, not considering the social characteristic of the illness and its relation with family behavior, both regarding its arrival and its evolution. When the educational process starts from a critical reflection of the family, searching for causes and consequences to the risk condition or to the already established problem, it is easier to delineate the actions needed to confront the disease. Thus, education gives the opportunity to emancipate these subjects.

Conversely, it can be observed that educational actions do not take place, specifically with the families, as only one of the participants responded to the query regarding how the educational activities are performed with the patient and his relatives. Because of that, we infer that the other respondents did not feel comfortable enough to assume that they do not include the family in their educational practices.

Based on this reality, it is important to provide a professional orientation according to the ideas that the strategies of education in health,

when used in a participative and interactive way, facilitate reflection and critical consciousness in people concerning their condition of life and health⁽¹²⁾, permitting a responsible engagement of all members of the family.

The information related to the clinical state of the patient and his treatment must be provided clearly so the family is able to decide what they consider beneficial for the patient. Therefore, the guidelines must be shared, so they enable the comprehension of the family, according to their cognitive and confrontation capacities⁽¹⁴⁾.

When making reference to the importance of the inclusion of the family in educational practices, it confirms the idea that education in health is a resource in which scientifically-produced knowledge, in the area of health, reaches out into the daily life of people⁽¹⁰⁾.

This understanding of the conditions of the process of illness-health will generate enough experience to be used in order to adopt new habits and conduction of health, reinforcing the relevance of the educational work of the families.

The actions in education in health require the participation of the user during the mobilization, capacitation, and development of the learning of the individual and their social abilities to deal with the processes of illness-health if based on a wider view of healthcare, extending the concretization of useful public policies⁽¹⁵⁾.

It is the responsibility of the health professionals to make efforts so that the changes in behavior occur throughout the continuous process of learning and the participation of the users, reflected in the ways they act upon the self, their families, and their surroundings, permitting the transformation of the people in an active and collective subject⁽¹⁶⁾.

The testimonials regarding the actual working conditions and the technical-scientific preparedness to practice the educational acti-

vities in health reinforce the verticalization of knowledge, characterized by the passive behavior of the learners and the centralization of the information by professionals.

Such conditions confirm the importance of the creation of human resources in health with proposals of actions aimed at the promotion of health during professional practices; this tuning is essential to strengthen and consolidate the Brazilian Unified Health System (SUS, in Portuguese), transforming the principles and directives of the system to become even stronger than before⁽¹⁵⁾.

Another relevant finding is in the views of the participants regarding professional learning, which is seen as the findings generated out of the working environment, supposedly in courses, lectures, and orientations, taking away from their own work as another format for learning.

To merge education with the daily life of health professionals is to recognize the educative potential of working conditions. In other words, it is also possible to learn at work. This premise aims to transform daily situations in learning, analyzing reflexively the problems of the practice, and valorizing the process of work of health professionals in its intrinsic context.

The perspective mentioned here, centered in the process of work, is not limited to certain professional categories, but to the whole team, including doctors, nurses, administrative staff, and all the variations of actors that compose the group. It is in the daily practice regarding permanent education that the educational process occurs in the praxis, giving conditions to develop educational practices beyond the views of promotion of health, and the empowerment that enables the individual to choose alternatives based on the data presented⁽¹⁷⁾.

Moving away from the traditional educational approach in the health labor learning processes, education must be considered as a collective

and solidary act that cannot be imposed. In other words, learning is done by being side-by-side, sharing experiences, and the educator cannot bring the answers ready from his own world, his own knowledge, his own method⁽¹⁸⁾, which justifies the criticism of the courses, lectures, and orientations that usually occur denying the context of work environments.

We must consider that continuous education and education in service are valuable tools to qualify health professionals. However, it is through permanent education that contextualized creativity allows for resolutions of the daily problems of the teams. We should not expect that only technical courses, in-service lectures, or any other modality of education will make them more suitable for work, because, in fact, the professional will never be ready, based on the dynamics of the production of knowledge.

It will be the articulation between theory and practice, from the criticality of the process of work, learning to be, learning to do, learning to learn, and learning to live together that will improve the professional's knowledge. That is the proposal of permanent education in health⁽¹⁹⁾.

On the other hand, the view without a critical perspective of the educational practice, as seen by the satisfaction regarding the conditions and the technical-scientific preparedness, signals that there is not one intrinsic movement for change. This change only occurs from the recognition of a problem-situation or a "limit-situation"⁽²¹⁾, capable of involving people in a search to overcome their own limited view, which is materialized in their actions. For Freire, the critical sight towards the actions of the self permits an individual to understand the limitation of the world, and, when observing this world as an unfinished work, it is possible to search for knowledge and change your own practice⁽¹⁹⁾.

As a conclusion, to recognize your own practice as a demand for learning is to project

new sights and to search for other alternatives for solution; such recognition can only occur if there are stimuli, through the use of an effective policy of permanent education that takes the professionals into a culture of daily reflective action. New pedagogical practices can be consolidated through the apprehension of real conditions that assist the teaching-learning process of matters of health based on the population, especially when dealing with a chronic disease⁽²⁰⁾.

CONCLUSION

It is understood that the educational practice present in these teams matches the standards of traditional teaching, centered in the disease, through a vertical approach of teaching-learning. This practice does not fit into the present necessities of co-accountability of the population to maintain their health and to valorize life above illness. The professional must amplify the holistic-ecological view, taking the educational activities to inside the families, empowering them in their emancipation.

Because of the lack of objectivity in the use of the expression of education in health, and in how to develop it by the participants of this study, we believe that permanent education in health is a strategy that would contribute to apprehending a new conception and action of the educational practice.

One limitation of this study is found in the fact that the data was obtained through written reports, instead of an oral format. An oral format could enable the participants to manifest their opinions freely about their perspectives and practices. Another limitation was the reduced number of informers, but they constitute the totality of higher level education professionals that work in the city, and this is the reality in the majority of the Brazilian municipalities away

from the largest metropolitan areas: there are few professionals responsible for the health of the population available in a Basic Care network.

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