http://dx.doi.org/10.1590/0104-07072016003670015

COMBINING VARIOUS FORMS OF TREATMENT TO HEALTH: A STUDY OF ELDERLY IN PRIMARY CARE

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ABSTRACT: The study aimed to analyze the contextual conditions that influence the use of medications in elderly assisted in primary health care. Qualitative study with contribution of Grounded Theory, held in Santa Cruz, Rio Grande do Norte, Brazil, where 30 elderly patients on medications were interviewed . Data were coded and a model consisting of nine categories was generated. The two categories that explain the contextual conditions of the phenomenon are, Interacting with the support network and The concurrent use of medicines, teas, home remedies and faith, but only the latter is the subject of discussion in this article. To accommodate various treatments, the elderly tried to understand and compare their functions and exercise the faith in God. The act of reconciling different treatments is part of contextual conditions that influence the phenomenon studied, creating a set of circumstances to which these seniors accounted seeking strategies to deal with drug use in daily life.

DESCRIPTORS: Drug utilization. Phytotherapy. Aged. Primary health care.

CONCILIANDO DIVERSAS FORMAS DE TRATAMENTO À SAÚDE: UM ESTUDO COM IDOSOS NA ATENÇÃO PRIMÁRIA

RESUMO: O estudo objetivou analisar as condições contextuais que influenciam o uso de medicamentos em idosos atendidos na atenção primária à saúde. Estudo qualitativo com aporte da Teoria Fundamentada nos Dados, realizado em Santa Cruz, Rio Grande do Norte, onde foram entrevistados 30 idosos em uso de medicamentos. Os dados foram codificados e geraram um modelo composto por nove categorias. As duas categorias que explicam as condições contextuais do fenômeno são: Interagindo com a rede de apoio e Conciliando o uso de medicamentos, chás, remédios caseiros e fé, sendo apenas esta última, objeto de discussão do presente artigo. Para conciliar diversos tratamentos, os idosos procuravam entender e comparar suas funções, além de recorrerem à fé em Deus. O ato de conciliar diferentes tratamentos faz parte das condições contextuais que influenciam o fenômeno estudado, criando um conjunto de circunstâncias às quais esses idosos respondiam buscando estratégias para lidar com o uso de medicamentos na vida diária.

DESCRITORES: Uso de medicamentos. Fitoterapia. Idoso. Atenção primária à saúde.

COMBINANDO DIFERENTES FORMAS DE TRATAMIENTO PARA LA SALUD: UN ESTUDIO DE ANCIANOS EN LA ATENCIÓN PRIMARIA

RESUMEN: El objetivo del estudio fue analizar las condiciones contextuales que influyen en el uso de medicamentos en ancianos en atención primaria de salud. Estudio cualitativo con la teoría fundamentada, en Santa Cruz, Rio Grande do Norte, Brazil, en el que se entrevistó a 30 ancianos en uso de los medicamentos. Los datos se codificaron y generaron un modelo consiste en nueve categorías. Las dos categorías que explican las condiciones contextuales del fenómeno son, Interacción con la red de apoyo, y Conciliar el uso de medicamentos, tés, remedios caseros y la fe, siendo solamente este último el tema de discusión en este artículo. Los ancianos trataron de entender y comparar sus funciones y volverse a Dios. El acto de conciliación de los diferentes tratamientos es parte de las condiciones contextuales que influyen en el fenómeno estudiado, crear las circunstancias a las que estes ancianos representaron buscando estrategias para hacer frente al consumo de medicamentos en la vida diaria.

DESCRIPTORES: Utilización de medicamentos. Fitoterapia. Anciano. Atención primaria de salud.

INTRODUCTION

One aspect that distinguishes modern man from those of other times is the high consumption of medicine, a practice adopted in different situations by having numerous studies that prove its effectiveness. However, one must also consider that the allopathic medicines are not the only substances used in health care, as people may seek other forms of treatment such as the use of plants and other natural products based on popular beliefs and religious rituals.[1]

When talking about health care in the elderly, it is assumed that those seeking different measures to take care of it, may be provided with recommendations from both professional, as well as cultural practices passed on from generation to generation.

In general, non-pharmacological treatments, based on folk customs and using vegetable, animal and mineral products, manual therapies and acupuncture, for example, are classified as elements of Traditional Medicine and Complementary and Alternative Medicine (TM/CAM). These terms were adopted by the World Health Organization, the organization which, in 2002, published a series of strategies to guide the implementation of this type of care in the health systems of many countries.[2]

In developing countries, the widespread use of TM/CAM can be attributed to the large access that is available to these therapies, especially among the poorest, such as Ghana, Kenya and Mali, as medicinal herbs usually cost less than allopathy.[2] In Brazil, we must consider that people use allopathic treatments as well as homeopathic treatments in health care, in 2006 the Ministry of health published the National Policy on Integrative and Complementary Practices (NPICP), to regulate existing experiences in the Brazilian Unified Health System (SUS), as well as to encourage and promote effective alternative actions and security.[3]

The NPICP aims to incorporate and implement the complementary and integrative practices in SUS, in the perspective of disease prevention, health promotion and recovery, with emphasis on primary care, focused on continued, humanized and comprehensive health care. It covers the areas of homeopathy, medicinal plants and herbal medicine, traditional Chinese medicine/acupuncture, anthroposophical medicine and social thermalism.[3]

Considering the complexity of the concept of current health, and the many attitudes that individuals adopt in the care of themselves and their family, when we talk about the use of medication in the elderly - the object of our study - we understand that this phenomenon involves, of course, many factors that deserve our attention. Home remedies concurrently used with pharmaceutical medicines, spiritual treatments and family care are examples of features that are commonly used by the elderly.

In our teaching practice in primary health care, it is common to come across elderly people taking care of their health, by employing different forms of treatment and seeking help from various people in the community and services, in the hope that diseases will be cured or, at least, their discomfort is minimized.

In order to understand this phenomenon, this study aims to analyze the contextual conditions that influence the use of medications in elderly patients in primary health care.

METHOD

A qualitative study with theoretical support of Grounded Theory (GT).[4] The study participants were elderly residents in the city of Santa Cruz-RN, who were patients of units of the Family Health Strategy (FHS). The choice of study location was due to the fact that it is the researcher's area of study in an extension project and the researcher is also a teacher in an undergraduate nursing degree program, whose practices and clinical experiences are developed around this context.

The first participants were contacted from the extension project meetings, as well as being indicated by the FHS professionals, especially by nurses and Community Health Agents (ACS). As the interviews were conducted in the elderly of the home, these indicated the next potential participant, following the snowball technique. To participate in the study, it was required that the subject was 60 years of age or older, and had used medication for at least six months. They excluded those who did not have cognitive conditions to respond to the research instrument and in order to verify this requirement, we used the Mini Mental State Examination (MMSE), using the score adopted by the Ministry of health as a basis.[5]

The study followed the steps required by the National Health Council No. 466/2012,[6] and was only initiated after approval of the Etichal Research Committee of *Universidade Federal de Santa Catarina* protocol n. 426573/2013. The confidentiality of information and the anonymity of participants was

maintained, they were identified using the first letters of their names followed by a number indicating their moment of entrance in the study, for example, SMC01. All 30 participants permitted audio recording of the interviews , and that the material be transcribed by the researcher and submitted for pre-analysis, open coding, axial and selective using Atlas.ti® software support.

The different stages of coding generated categories and subcategories, and for better viewing, they have been described as a model/paradigmatic scheme (Figure 1), which clarifies the relationship between the categories and how these influence the phenomenon of medicine use by the elderly.[4]

Thus, following the TFD framework, the aforementioned paradigmatic model provides a graphical representation of the actions/interactions, consequences, causal conditions, intervening and contextual phenomenon. The contextual conditions - which will be discussed below - are those that create the set of circumstances or problems to such people, in this case, the elderly, who responds through actions/interactions. In the research that led to the present manuscript, actions/interactions are portrayed by categories, searching for strategies to deal with medicine use in daily life.

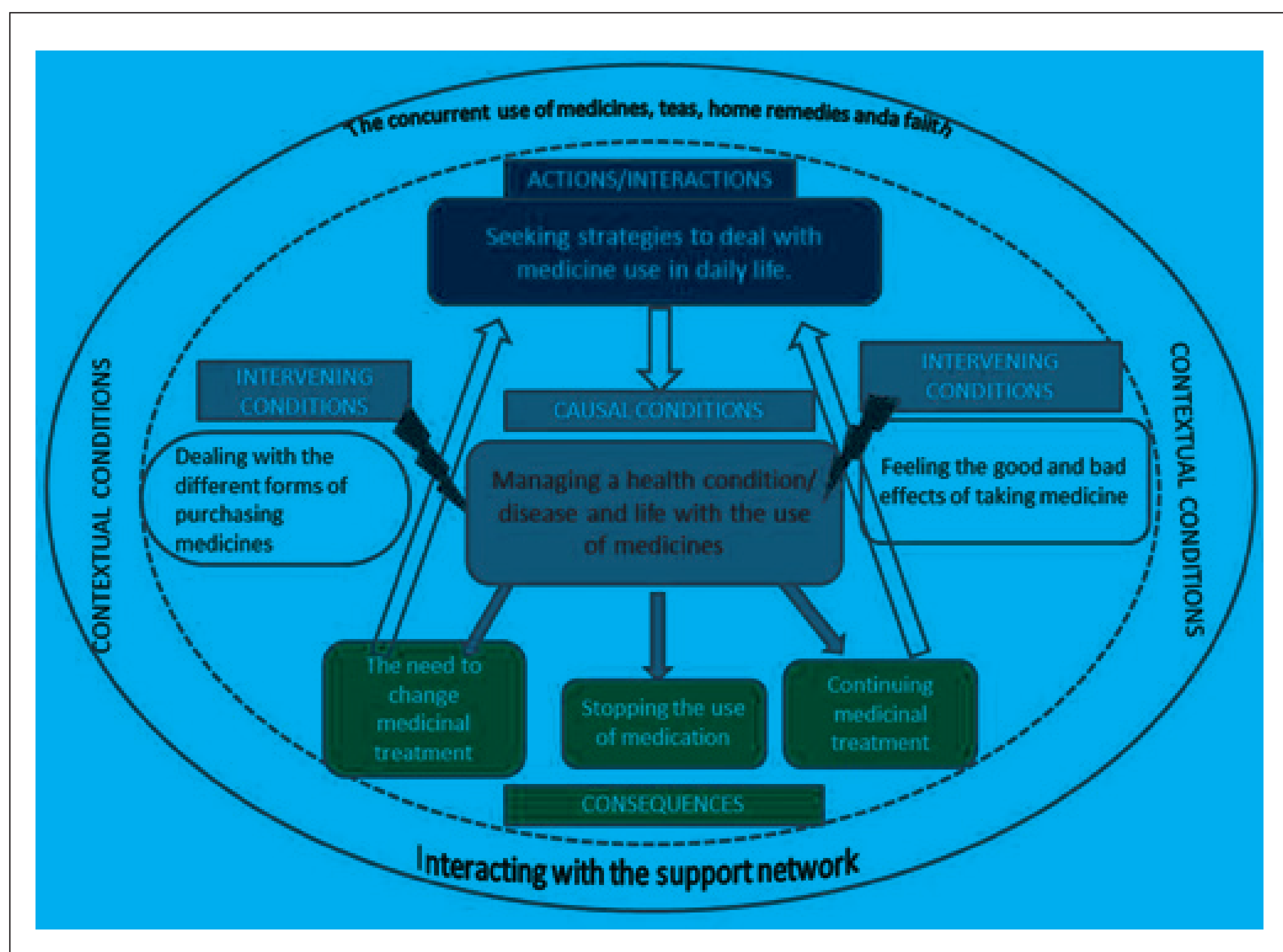

Figure 1 - The paradigmatic scheme based on the Strauss and Corbin model[4]

The categories that explain the contextual conditions of the phenomenon are: Interacting with the support network and the concurrent use of medicines, teas, home remedies and faith, only the latter, the subject of this article, presented in conjunction with its three subcategories.

RESULTS AND DISCUSSION

The concurrent use of medicines, teas, home remedies and faith

It is possible to say that the elderly participants in this study concurrently used different forms

of treatment, because out of the 30 participants, all used at least one medicine , ranging from one to ten different medicines. Twenty-four of the respondents mentioned the use of at least one home remedy, ranging up to eight mentioned remedies. All declared following a religion (27 Catholics and three Evangelical), indicating faith as a therapeutic element. Thus, this category is structured by three subcategories, shown in Figure 2.

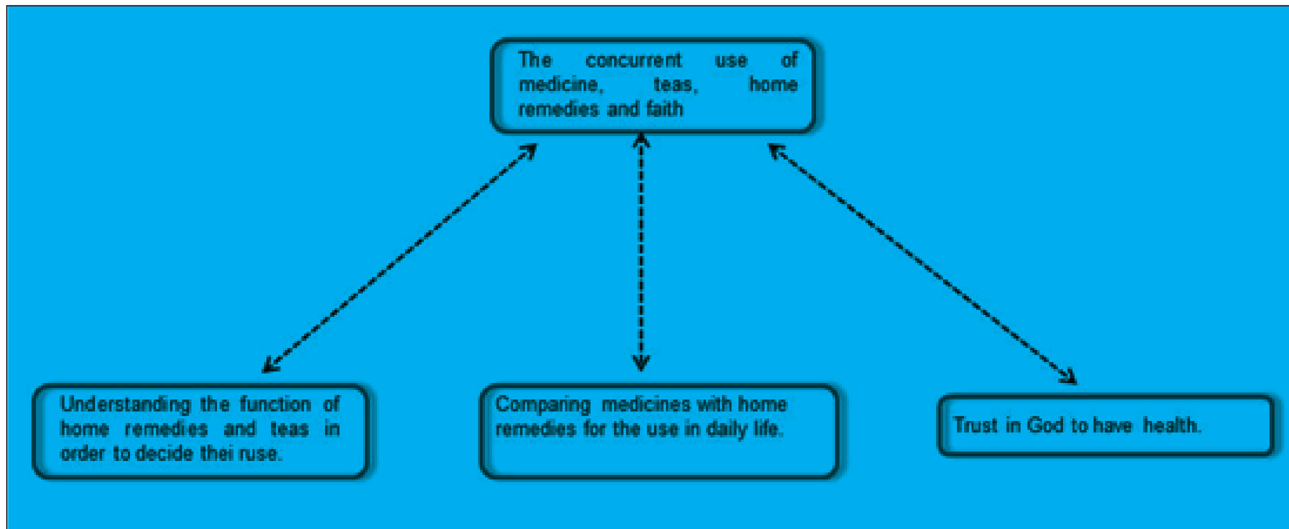

Figure 2 - Diagram of the category: The concurrent use of medicines, teas, home remedies and faith (contextual condition)

The fact of there being different forms of treatment included questions that required extensive discussion considering that the healing practices - domestic and public - originating ethnic groups and mestizo populations, as present in South American countries, are an integral part of the forms of life, the value systems and the significance of the culture of these places, forming true complex medical systems. These are characterized as healing systems in which the integration man/nature and nature/culture represent balance and health security for individuals and communities.[7]

Understanding the function of the home remedies and teas in order to decide their use

In this study, the use of home remedies and teas gain meaning from the descriptions that participants gave to explain how, when, why and who used these treatments. Also present in their descriptions, based on their experiences, was with whom they learned and who taught them, and how to qualify the practice as good or bad. These explanations provide explanations for the phenomenon and are considered structuring for the sub-category[4] as they allow the description of the category, The concurrent use of medicines, teas, home remedies and faith in terms of properties and dimensions.

We say that free codes "serving teas" and "the reason to use teas" are associated because often when talking about the role that the particular herb has, the subject justified its use. The free code "the reason for serving tea" includes 20 other codes *in vivo* and their respective comments.

Only a little tea, if I need it. A chamomile tea, for when I'm not sleepy. They say it's good (MGS16).

A survey of the elderly who were patients of a basic health unit[8] identified 14 types of plants used by them in the treatment of hypertension, the colony and lemongrass were identified as the most used. Lemongrass was also frequently mentioned in our study and has proven to be soothing and contain a light antispasmodic action, considered virtually risk free due to having low toxicity.

In our study, five respondents mentioned the use of other home remedies for the treatment and control of blood pressure, namely, rosemary (*Rosmarinus officinalis L.*, cited by two elderly), chamomile (*Matricaria recutita*), dill (*Anethum graveolens*) and chayote (*Sechium edule*). The last two plants have anti-hyperlipidemic properties (Dill) and hypotensive (chayote), or are able to exert effects on the cardiovascular system.[8-9]

Moreover, rosemary and chamomile have proven antispasmodic and anti-inflammatory action

and are used to relieve abdominal cramps,[10-13] not mentioning any antihypertensive or diuretic effects in the consulted references.

But the code "the reason to use teas?," and the commentaries associated with it, explain the reasons why some older people used the tea in their routine. Some considered the tea as a drink that is part of their diet, while others saw it as a substitute for the drug, showing their confidence in this therapy.

It's because it's routine, you know? To avoid drinking coffee, I drink tea. They say it has ... it serves as a remedy. But I drink it because I do not drink coffee after dinner. So, I drink tea so I don't drink coffee (JOP03).

I'm trying, right now, only with tea! The tablets were giving a lot of stomach pain. The pressure tablets were giving me a lot of pain in the stomach (FCN07).

This last line shows that the elderly seemed to believe that tea is less harmful when compared to the effects that the medicine was causing him. Other authors found, when interviewing older men who used medicines and teas, that the representations of medicinal plants seemed to be anchored in the concept of security, that is, being a natural, and would present few collateral effects.[14]

The participants also taught us how the teas should be used, since many reserved it for times when certain symptoms appeared or became troublesome, as highlighted by the comments of a following informant:

just sometimes, I drink boldo tea. She [the wife] *makes the boldo tea and I drink it. I sometimes have a bad stomach, then my wife makes it. I drink it for two or three days* (GF09).

Not using the tea daily can be explained by another code, "take the risk of using tea", since participants pondered its benefits and harms. The use of medicinal plants can promote health, as long as the user has prior knowledge of their purpose, risks and benefíts.[10]

I liked tea, but that's not what I'm telling you, I'm not taking it right now because I do not know due to my problem, if I should. Because of CA [cancer], *then I don't know if I can drink it. If it's good for one thing but aggravates another* (FRLS21).

So, teas ... the way they can do good, but they can also do harm, if you do not take the right amount, if it's not done correctly ... then how will I [know]*?* (MMFL23).

In some cases, the use of tea was recommended, with some exceptions, by health professionals, which helps to legitimize this practice as something safe, since their recommendation is from someone who has knowledge about the health of the elderly.

A survey of the FHS physicians pointed out that 77.8% of these professionals used herbal medicine in their personal life and 70.4% recommended it to their patients.[15]A similar situation is also found in this study, as can be seen in the report below:

my doctor during Christmas, there [in the University Hospital] *Onofre Lopes, my kidney doctor, you know? When I went, she told me to just take peppermint tea, she said not to use another* [kind of] *tea.* [...] *it wouldn't be good for me, because I have kidney problem* (MSA25).

Although all participants lived in urban areas, they all had origin in rural Santa Cruz and neighboring municipalities, which reinforces the strong backlands tradition of respecting and following popular beliefs and therefore including the use of teas in their routine. Although it has not been explicit in the comments of all the participants, some participants mentioned the fact of learning and teaching about the teas, as a way of perpetuating such a popular custom.

I have it there. I drink it, make some tea and drink it. Only this, the rosemary tea. It's what I do and teaching also for the others [the friends] (GAO02).

Ih ... it's what grandmothers do... [laughs] *passed on from mothers...* (MLSF08).

Knowledge about the use of teas is usually passed on from previous generations - mothers and grandmothers - and is transmitted to people who make up the circle of family and friends of the elderly. It was from these people that the older people have learned how to prepare and use the teas, which in turn also helps us understand the practice of using teas.

The transfer of knowledge of medicinal plants favors not only the maintenance of health, it can also represent the preservation of local knowledge, culture and customs of the people.[16]

Some seniors mixed more than one herb together in one preparation, others waited for the drink to go cold so they could drink it, and there are still those who associated the preparation with certain religious rituals.

On Palm Day, we take the holy lemongrass, which we give to the priest at the time of blessings, for him to give the blessing to the lemongrass [...] *Then I bring the tea home for when the people are sick* (ERS04).

This participant, ERS04, claimed not to use teas, although possessed various herbs which were planted in his home and followed the aforemen-

tioned ritual. The way he explained the holy lemongrass becoming effective only upon the blessing of the priest, and shows a kind of syncretism to join popular knowledge and the Catholic faith in the favor of health.

One of the interviewees explained that, although people usually use the *mastruz* to make teas, she used the herb in another way, as he considered the smell as unpleasant, as can be read below:

I never make that tea ... there are people who make tea, wash the head with it and all, [but] *I do not. Would I put it in my head!?* [laughs] *A damned smell!* [laughs] *I like the little leaf, I wash it well, chew, suck everything that is mixed together and spit it out* (SMC01).

Practitioners of complementary therapies have knowledge and techniques that can be important allies to health promotion, considering that these practices value and foster solidarity, exchanges between individuals, social and political participation, and thus the community empowerment, contributing to the construction of social supporting networks.[17]

Comparing medicines with home remedies for the use in daily life

The adoption of medicines and/or homemade remedies is something present in life and, due to this, some elderly people ponder its risks and benefits, and seek to understand the similarities and differences between the two types of therapy.

The medicine from the pharmacy, prescribed by the doctor, I know it has it all, a little bit of everything, they put it in to make that syrup. If they put a lot of tea leaves in the home remedy, it may not even work (IVN17).

Remedy is made from bush! There is nothing else! (FRLS21).

The last two lines show that the elderly person had the understanding that the drug sold in the pharmacy is produced from plants, noting that the first would have a better adjustment in the concentration of substances, compared to that which is prepared in the homemade way. A study found that 81% of respondents would like to receive herbal medicines from SUS as well as being given seedlings for cultivation at home.[18]

We understand that what is referred to as "pharmacy medicine" and "home remedy" for the elderly represent herbal medicines and medicinal plants, respectively. Given the above, we consider it important to clarify the difference between the terms using the definitions contained in the National Policy of Medicinal Plants and Herbal Medicine.[19] Medicine is defined as a pharmaceutical product, technically obtained or prepared, while herbal medicine is characterized by the use of medicinal plants in different pharmaceutical preparations. As medicinal plants include vegetables, cultivated or not, used for healing purposes.[19]

Another important aspect is the idea that home remedies are safer than allopathic, a notion championed by those who explain the preference for a natural treatment to the detriment of symptomatic medicines, when an ailment appears. These aspects were reported by the subjects of this research.

When I'm feeling something, I run to my prepared teas, I like to drink them ... to help with that problem I'm feeling. Sometimes I feel a pain, I have a headache, but the headache is sometimes when I'm having difficulty with family. Okay, I take it like this. When I have a headache, I like to drink [tea]. *I used to drink Anador, I cannot take Anador anymore* (JBP22).

People who prefer to use natural products do so believing that the plants have healing power and generate less side effects compared to allopathic medicines.[16]

Another situation found was the case of the elderly who sought the home remedy because, according to her, the FHS doctor refused to treat her with medicine, even when she presented the results of a parasitological examination that proved the presence of a parasitic disease.

I take homemade remedies like this: because she [the doctor] *did not want to use medicine for amoeba, so I take homemade remedies* (FCN07).

With regard to home treatment of gastrointestinal symptoms, the elderly respondents mentioned the use of: pumpkin seeds, lemongrass, fine leaf mint, boldo, rosemary, 'seven pain tea' and beet juice with carrot, papaya and mint.

A study of people between 19 and 86 years of age showed that the problems treated the most with medicinal plants were acute and transient manifestations of the digestive tract, anxiety disorders, respiratory system diseases and headache.[20]

The aspects discussed herein reveal that most of the elderly respondents were using some type of home remedy or tea and often used them along with allopathic medicines. This practice, commonly based on the popular culture, is already part of the reality of primary care services and therefore cannot be disassociated from the health professional in this context.

Complaints of nervousness, stress and anxiety are common among the elderly, especially when

they feel continuous pain and in this way, the introduction of complementary practices as part of health care can improve the quality of life of this population.[21]

Thus, the involvement of professionals in the search for knowledge about complementary and integrative practices is necessary in order to prevent the spread of misconceptions and that alternative therapeutic options to the biomedical model to be offered with greater security. With the intention, the introduction of the subject into the curricula of health courses is recommended, as well as greater availability of training and dissemination of these issues to strengthen the implementation of NPICP in municipalities.[22]

Trust in God to have health

The elderly respondents generally sought various forms of care, while they put their hope of recovery and relief in faith in God. All participants declared themselves Christians and it was common to hear reports that related to health and religion.

In the Mass of healing and deliverance, the person with living faith is healed, right? [Healed] *of certain diseases* (MSF10).

The lemongrass is more to ... how do you say ... you take it for... [for] *soothing, but thank God I do not drink it, because I have my God and I cannot lose my nerves . My nerves are not imbalanced, no* [...]. *I don't drink it!! I have faith in God, God is going to give me health* (IVN17).

Other authors found an association between religiosity and higher quality of life among older adult patients of the FSH in a city in Minas Gerais. However, study data found no relationship between religiosity and depression by applying validated instruments such as the Geriatric Depression Scale.[23] Thus, it is recommended that religion be taken into account during the planning of elderly health care, not only as a way to improve their quality of life but also for the professional to show respect for the beliefs of the subjects.[23]

Many people attribute the appearance or resolution of the health problems to God and often turn to him as a resource to face the problems.[24]

When I had these things, God spoke to me. He said: 'These diseases are not meant for death. It's to the honor and glory of my name.' that's why I did not cry, nor lost weight, because God is not pleased with uncharitable sick people, no [...]. *No. I suffer with patience that God passes over everything. Then, thanks to God, so far, the Lord has helped me, you know? In these things. And it will help me until the day that he will take me, because we don't have life. Life is God. Our life is God. We spend our time here only as long as he has already determined* (IVN17).

In this case, the reason for the recovery of elderly health status was assigned to the spiritual level and a way to show respect to God was demonstrated by gratitude and acceptance of the disease, which seems to feed the hope and the ability of the elderly to overcome hard situations.

Religiosity gives meaning to life to the suffering, to create a social support network.[25] Spirituality appears as a strong indicator of resilience among the elderly, as the search for the meaning of life and faith help them to overcome the most significant adverse events in their lives.[26]

FINAL CONSIDERATIONS

The daily practice of using drugs manifests itself as an important aspect in the lives of elderly respondents, given that in many cases, drug therapy plays a central axis in health care. However, to carry out these open questions to the participants, their responses indicated a wide range of used informal resources, all of which may end up going unnoticed because in general they are not included in the family records. In studies like this, the concurrent use of medicines (prescription and non-prescription), home remedies, in addition to belief in faith in God to heal their problems, was common.

In studies like this, supported by the GT, the description of how contextual conditions affecting the phenomenon studied in a micro or macro perspective, or rather, how they influence in more focal or global way, is essential.

The act of combining different treatments is part of the contextual conditions that influence the phenomenon studied. But if we want to understand the macro context, we must expand our vision to understand that other more global contextual conditions, not mentioned directly by the participants, may influence the use of medicines in this reality. When considering that all respondents were elderly and patients of the FHS and used medicines, bought and acquired free of charge to take care of their health, it is inevitable to see that they were all subjected to the constant rights and duties of current policies that affect: the National Medicines Policy, the National Policy on Health Promotion, the National Policy of Primary Care. Following this reasoning, we would have to admit that, in addition to the contextual conditions already discussed, there would be a corresponding macro context to the aforementioned policies in our paradigmatic model.

However, respecting the principles of GT in which theory must emerge from data, the inclusion of this macro context in the created paradigmatic model would be something artificial, given that this was a matter that did not appear in the comments, but only arises from our reflection.

REFERENCES

1. Veiga Junior VF. Estudo do consumo de plantas medicinais na Região Centro-Norte do Estado do Rio de Janeiro: aceitação pelos profissionais de saúde e modo de uso pela população. Rev Bras Farmacogn [internet]. 2008 Abr-Jun [cited 2015 Mar 18]; 18(2):308-13. Available from http://www.scielo.br/scielo.php?pid=S0102-695X2008000200027&script=sci_arttext
2. World Health Organization (WHO). Traditional medicine strategy 2002-2005 [internet]. Geneva: WHO; 2002 [cited 2015 Mar 18]. Available from http://www.wpro.who.int/health_technology/book_who_traditional_medicine_strategy_2002_2005.pdf
3. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Política Nacional de Práticas Integrativas e Complementares no SUS – PNPIC-SUS. Brasília (DF): Ministério da Saúde; 2006.
4. Strauss A, Corbin J. Pesquisa qualitativa: técnicas e procedimentos para o desenvolvimento de teoria fundamentada. 2ª ed. Porto Alegre (RS): Artmed; 2008.
5. Ministério da Saúde (BR), Secretaria de Atenção à Saúde. Envelhecimento e saúde da pessoa idosa: caderno de atenção básica nº.19. Brasília (DF): Ministério da Saúde; 2006.
6. Ministério da Saúde (BR), Conselho Nacional de Saúde, Comissão Nacional de Ética em Pesquisa. Resolução CNS nº 466, de 12 de Dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília (DF): Ministério da Saúde; 2012.
7. Luz MT. Cultura contemporânea e medicinas alternativas: novos paradigmas em saúde no fim do século XX. PHYSIS: Rev. Saúde Coletiva [internet]. 2005 Dez [cited 2015 Mar 22]; 15 (Suppl):145-76. Available from: http://www.scielo.br/pdf/physis/v15s0/v15s0a08.pdf
8. Oliveira CJ, Araújo TL. Plantas medicinais: usos e crenças de idosos portadores de hipertensão arterial. Rev Eletr Enferm [internet]. 2007 Jan-Abr [cited 2015 Mar 22]; 9(1):93-105. Available from: http://www.fen.ufg.br/revista/v9/n1/v9n1a07.htm.
9. Rodrigues DT, Machado MI, Matias DB, Oliveira MR, Ceretta LB, Becker IRT, et al. Evaluation of the use of medicinal plants in a group with hypertension in a NFHS unit of a neighborhood in the city of Criciúma. Rev Inova Saúde [internet]. 2013 Jul [cited 2015 Nov 10]; 2(1):47-67. Available from: http://periodicos.unesc.net/Inovasaude/article/view/1203/1262
10. Badke MR, Budó MLD, Silva FM, Ressel LB. Plantas medicinais: o saber sustentado na prática do cotidiano popular. Esc Anna Nery. 2011 Jan-Mar; 15(1):132-9.
11. Falkowski GJS, Jacomassi E, Takemura OS. Qualidade e autenticidade de amostras de chá de camomila (Matricaria recutita L. – Asteraceae). Rev Inst Adolfo Lutz [internet]. 2009 Abr [cited 2015 Mar 26]; 68(1):64-72. Available from: http://revistas.bvs-vet.org.br/rialutz/article/view/7065
12. Morais TC, Vieira MC, Heredia Z, Teixeira IR, Ramos MBM. Produção de biomassa e teor de óleos essenciais da camomila [Chamomilla recutita (L.) Rauschert] em função das adubações com fósforo e nitrogênio. Rev Bras Pl Med Botucatu [internet]. 2006 Out-Dez [cited 2015 Mar 28]; 8(4):120-5. Available from: http://www.sbpmed.org.br/download/issn_06_3/artigo24_v8_n4.pdf
13. Morais SM, Cavalcanti EB, Costa SMO, Aguiar LA. Ação antioxidante de chás e condimentos de grande consumo no Brasil. Rev Bras Farmacogn [internet]. 2009 Jan-Mar [cited 2015 Mar 28]; 19(1B):315-20. Available from: http://dx.doi.org/10.1590/S0102-695X2009000200023
14. Lima SCS, Arruda GO, Renovato RD, Alvarenga MRM. Representações e usos de plantas medicinais por homens idosos. Rev Latino-Am Enferm [internet]. 2012 Jul-Ago. [cited 2015 Mar 30]; 20(4):778-86. Available from: http://dx.doi.org/10.1590/S0104-11692012000400019
15. Rosa C, Câmara SG, Bérias JU. Representações e intenção de uso da fitoterapia na atenção básica à saúde. Cien Saúde Coletiva [internet]. 2011 Jan [cited 2015 Mar 30]; 16(1):311-8. Available from http://dx.doi.org/10.1590/S1413-81232011000100033
16. Tomazzoni MI, Negrelle RRB, Centa ML. Fitoterapia popular: a busca instrumental enquanto prática terapêutica. Texto Contexto Enferm [internet]. 2006 Jan-Mar [cited 2015 Abr 02]; 15(1):115-21. Available from: http://www.scielo.br/pdf/tce/v15n1/a14v15n1.pdf
17. Tesser CD. Práticas complementares, racionalidades médicas e promoção da saúde: contribuições poucos exploradas. Cad Saúde Pública [internet]. 2009 Ago [cited 2015 Abr 05]; 25(8):1732-42. Available from: http://dx.doi.org/10.1590/S0102-311X2009000800009
18. Maravai SG, Costa CS, Lefchako FJ, Martinello OB, Becker IRT, Rossato AE. Plantas medicinais: percepção, utilização e indicações terapêuticas de usuários da estratégia saúde da família do município de Criciúma-SC vinculados ao PET-Saúde. Arq Catarin Med [internet]. 2011 Out-Dez [cited 2015 Abr 05]; 40(4):69-75. Available from: http://www.acm.org.br/revista/pdf/artigos/899.pdf
19. Ministério da Saúde. (BR). Política Nacional de Plantas Medicinais e Fitoterápicos. Brasília (DF): Ministério da Saúde; 2006.

20. Teixeira AH, Bezerra MM, Chaves HV, Val DR, Pereira Filho SM, Silva AAR. Conhecimento popular sobre o uso de plantas medicinais no município de Sobral, Ceará/Brasil. Sanare [internet]. 2014 Jan-Jun [cited 2015 Abr 06]; 13(1):23-8. Available from: http://sanare.emnuvens.com.br/sanare/article/view/429/284
21. Freitag VL, Dalmolin IS, Badke MR, Andrade A. Benefits of Reiki in older individuals with chronic pain. Texto Contexto Enferm [internet]. 2014 Out-Dez [cited 2015 Abr 08]; 23(4):1032-40. Available from: http://dx.doi.org/10.1590/0104-07072014001850013
22. Thiago SCS, Tesser CD. Percepção de médicos e enfermeiros da Estratégia de Saúde da Família sobre terapias complementares. Rev Saúde Pública [internet]. 2011 Abr [cited 2015 Abr 10]; 45(2):249-57. Available from: http://www.scielo.br/pdf/rsp/v45n2/2243.pdf
23. Chaves ECL, Paulino CF, Souza VHS, Mesquita AC, Carvalho FS, Nogueira DA. Quality of life, depressive symptoms and religiosity in elderly adults: a cross-sectional study. Texto Contexto Enferm [internet]. 2014 Jul-Set [cited 2015 Abr 11]; 23(3):648-55. Available from: http://dx.doi.org/10.1590/0104-07072014001000013
24. Faria JB, Seidl EMF. Religiosidade e enfrentamento em contextos de saúde e doença: revisão da literatura. Psicol: reflexão e crítica [internet]. 2005 Set-Dez [cited 2015 Abr 11]; 18(3): 381-9.. Available from: http://www.scielo.br/pdf/prc/v18n3/a12v18n3.pdf
25. Mello MN, Oliveira SS. Health, religion and culture: a dialogue based on Afro-Brazilian customs. Saúde Soc [internet]. 2013 Out-Dez [cited 2015 Abr 14]; 22(4): 1024-35.. Available from: http://dx.doi.org/10.1590/S0104-12902013000400006
26. Silva AI, Alves VP. Envelhecimento: resiliência e espiritualidade. Diálogos possíveis. [internet] 2007 Jan-Jun [cited 2015 Abr 17]; 6(1):189-210. Available from: http://www.faculdadesocial.edu.br/dialogospossiveis/artigos/10/14.pdf

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Received: July 21, 2015
Approved: February 12, 2016