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ORIGINAL ARTICLE

Comprehensiveness in child healthcare teaching in Undergraduate Nursing: perspective of teachers*

INTEGRALIDADE NO ENSINO DA SAÚDE DA CRIANÇA NA GRADUAÇÃO EM ENFERMAGEM: PERSPECTIVA DE DOCENTES

INTEGRALIDAD EN LA ENSEÑANZA DE LA SALUD INFANTIL EN LOS ESTUDIOS DE PREGRADO DE ENFERMERÍA: PERSPECTIVA DE LOS DOCENTES

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ABSTRACT

This qualitative study analyzed, from the teacher's perspective, if the principle of comprehensiveness is included in child healthcare teaching in nursing education. The participants were 16 teachers involved in teaching child healthcare in eight undergraduate nursing programs. Data collection was performed through interviews that were submitted to thematic content analysis. The theory in teaching incorporates comprehensive care, as it is based on children's epidemiological profile, child healthcare policies and programs, and included interventions for the promotion/prevention/rehabilitation in primary health care, hospitals, daycare centers and preschools. The comprehensive conception of health-disease process allows for understanding the child within his/her family and community. However, a contradiction exists between what is proposed and what is practiced, because the teaching is fragmented, without any integration among disciplines, with theory dissociated from practice, and isolated practical teaching that compromises the incorporation of the principle of comprehensiveness in child healthcare teaching

DESCRIPTORS

Education, nursing
Comprehensive Health Care
Child health
Pediatric nursing

RESUMO

Estudo qualitativo que analisou, na perspectiva de docentes, se o ensino da saúde da criança incorpora o princípio da integralidade na formação de enfermeiros. Participaram do estudo 16 docentes envolvidos no ensino da saúde da criança em oito cursos de graduação. Coletou-se dados por entrevistas submetidas à análise de conteúdo do tipo temática. Na teoria, o ensino incorpora a integralidade, pois tem como base o perfil epidemiológico infantil, políticas e programas de atenção à criança e inclui ações de promoção/prevenção/reabilitação na atenção básica, hospitalar, creches e pré-escolas. Apesar da concepção ampliada do processo saúde-doença, que possibilita compreender a criança inserida em família e comunidade, há contradição entre o que se propõe e o que se efetiva na prática, pois o ensino é fragmentado, sem integração entre disciplinas, teoria dissociada da prática e ensino prático pontual que comprometem a incorporação da integralidade no ensino da saúde da criança.

DESCRITORES

Educação em enfermagem
Assistência Integral à Saúde
Saúde da criança
Enfermagem pediátrica

RESUMEN

Estudio cualitativo que analizó si la enseñanza de la salud infantil incorpora el principio de la integralidad en la formación en enfermería, desde la perspectiva de docentes. Participaron en el estudio 16 docentes involucrados en la enseñanza de la salud infantil en ocho cursos de pregrado. Los datos fueron recolectados por medio de entrevistas y sometidos a análisis de contenido temático. En teoría, la enseñanza incorpora la integralidad, pues tiene como base el perfil epidemiológico infantil, las políticas y los programas de atención al niño e incluye acciones de promoción/prevención/rehabilitación en atención primaria, hospitales, guarderías y centros preescolares. A pesar de la concepción ampliada del proceso salud-enfermedad, que permite comprender al niño inserto en su familia y comunidad, hay contradicción entre lo que se propone y lo que efectivamente se realiza en la práctica, pues se evidenció una enseñanza fragmentada, sin integración entre las disciplinas, con la teoría disociada de la práctica y una enseñanza práctica puntual que comprometen la incorporación del principio de la integralidad.

DESCRIPTORES

Educación en enfermería
Atención Integral de Salud
Salud del niño
Enfermería pediátrica

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INTRODUCTION

The education of healthcare professionals poses a challenge for changing healthcare practice and improving the population's health status. The implementation of the Unified Health System (SUS, as per its acronym in Portuguese) in Brazil brought the special challenge of redirecting nursing practice and teaching towards comprehensive healthcare. In order to act in this scenario, professionals must be trained to become sensitive to the needs of the population[1], and to incorporate the psychosocial dimension and actions of health promotion, protection, recovery and rehabilitation in their practice, thus guaranteeing continuous care across different complexity levels, combining a set of policies through intersectoral actions[2].

The comprehensiveness principle is a guiding concept of the SUS (national health system). The principle is expressed as a set of connected, continuous, preventive and curative actions and services in all levels of complexity of the system[3]. However, different meanings and values have been assigned to this principle, assigning it a polysemic notion. For one expert, the term expresses a *battle flag* and points out desirable characteristics of the healthcare system and the professional practice, thus composing three major sets of meanings: the first refers to the governmental responses to healthcare needs by means of policies that articulate preventive and care actions; the second involves the healthcare system and service flow framework; the third assesses the healthcare practice of the professionals[4].

The hegemonic health system, however, focuses on the disease and on an individual, curative, hospital-based, specialized care limited to provide responses to complaints, thus keeping it very far away from the notion of comprehensiveness. Even now, such biomedical model predominates in the healthcare education and the care is bound to the ill part, rather than to an approach of the subject in his/her singularity[5]. This structure exerts quite a powerful impact on the education of healthcare professionals. Therefore, in spite of the critique, the hegemonic conception of healthcare teaching is *grounded on contents and organized in a compartmentalized, isolated way, thus fragmenting the individuals into clinic specialties*[6].

Historically, pediatric nursing education has also focused on pathology and the technical-operational procedures of hospitalized children[7]. This occurs despite the fact that the proposal for comprehensiveness appears in the national curriculum guidelines for nursing undergraduate courses and child healthcare policies present a more comprehensive care philosophy.

Comprehensive healthcare for children means caring them in full, as beings in development, who have a socially determined health-disease process. Hence, their life conditions and family context affect their epidemiological profile. Children , therefore, must be cared for considering their biopsychosocial aspects, i.e., with an attachment between family, healthcare professionals and institutions, and the community[8].

This approach, nonetheless, remains far from being achieved in professional practice due to the fragility and fragmentation of the actions implemented by service network professionals[9-12]. On the other hand, there is clear evidence that in nursing education, the teaching plans regarding child healthcare include the principle of comprehensiveness[13].

Hence, given the need to prepare professionals to incorporate the comprehensiveness principle in their practices, the present study aimed to assess, from the teacher's perspective, whether or not the current child healthcare teaching applies the comprehensiveness principle in nurses' education.

METHOD

This qualitative, descriptive study was carried out in eight public institutions that offer nursing undergraduate courses. The intentional sample was selected in Brazilian regions displaying the largest numbers of undergraduate courses (Southeast and Northeast) and four states (Sao Paulo, Rio de Janeiro, Bahia and Pernambuco) presenting more traditional schools producing relevant technical-scientific knowledge in the nursing field. Sixteen teachers, indicated by the coordination of the courses, participated in the study. All participants were effective nurse teachers involved in child healthcare teaching, in either primary care or hospital care.

The data were collected by means of semistructured interviews performed in the teachers' original institutions between August of 2010 and March of 2011. After the transcription of the interviews, the information was submitted to thematic content analysis developed in three stages: pre-analysis, selection of analysis units and categorization process[14]. For that purpose, the interviews were read several times so that the full meaning of the contents could be apprehended and emerging issues identified. The study was then organized, interpreted and each issue assessed along with the respective portions of the statements, thus revealing meanings and perceptions of the teachers concerning the comprehensiveness principle in child healthcare, considering the comprehensiveness theoretical framework as the analytical category.

The study complied with the requisites proposed by Resolution 196/96 of the National Health Council and was approved by two Research Ethics Committees under protocol numbers 892/2010 and 087/2010.

RESULTS

The thematic analysis allowed for the identification of two categories: elements that bring the child healthcare education closer to the comprehensiveness principle, and elements that keep the child healthcare education away from the comprehensiveness principle.

Elements that bring the child healthcare education closer to the comprehensiveness principle

From the perspective of all interviewed teachers, comprehensive child healthcare means connecting children to broader family and social contexts. The statements showed a conception of comprehensiveness beyond biological aspects, looking at the child in her totality and considering the social determinants of health.

> Comprehensive care means to see the child […] within the family context and within the social context of the community. Our work is grounded on this type of premise all the time. If the child presents, for instance, any complaint, the whole context, her home, the society where she lives, the family, need to be considered and not only that respiratory problem […] because these conditions are not only individual situations, but family situations, collective situations (E1).

> What is going on with this kid that he has so many hospitalization processes? What happens in his home? That problem may be much more connected to the family than to the community […] if that child stays in a daycare center all the time, we should be concerned about what is going on. If the kid 'wheezes' very much, we have to check out what is causing that at the daycare center or at his home (E11)

Another testimony highlighted the relevance of the home visit as a strategy toward developing the comprehensiveness teaching, as this action brings students closer to the child's social reality.

> [in] the home visit to the children, [the student will] check out the home environment, the inclusion of the family, their work status […] we discuss each case, take notes and whenever necessary I convey the case to the teams (E9).

The teachers point out that the theoretical content of the child healthcare teaching is based upon child-based public policies (governmental responses to children's health needs), among them the Comprehensive Children' Healthcare Program (PAISC, as per its acronym in Portuguese), the Integrated Management of Childhood Illness (AIDPI, as per its acronym in Portuguese), the Commitment Agenda for Comprehensive Childhood Healthcare and Child Mortality Reduction. Additionally, the public policies also deal with the national and local epidemiologic profile of children.

> our theoretical framework primarily deals with morbidity-mortality indicators, then the public policies, the PAISC, the lines of the Agenda, the humanization of labor and childbirth (E15).

> we think that students are exposed to contents aligned to our epidemiologic profile, we teach them about diarrhea, malnutrition and anemia (E6).

As for the integration of promotion, protection, recovery and rehabilitation actions, the testimonies showed that the child health teaching encompasses the primary care and the hospital network.

The practical teaching was also highlighted in other childcare contexts, such as daycare centers and preschools, which allow for several opportunities of learning about health promotion and disease prevention actions in a practical way.

> The second year of the course is utterly directed to health promotion and prevention disciplines, the practice is entirely carried out within the extra-hospital context, and students attend primary care units. They also work in kindergartens or daycare centers [where they] […] assess and promote child development activities (E1).

Some testimonies showed the existence of initiatives aimed to devise the integration of theoretical and practical contents in child health disciplines toward comprehensiveness:

> The idea is to integrate a woman's health teacher and a children's health teacher, because, as a matter of fact, they just can't work separately. That's the moment when you deal with the mother and the baby and […] the family. So, within the comprehensiveness principle, it is not possible to deal with the child or the woman separately anymore, it's the binomial that counts (E13).

The proposal for the integrated curriculum of contents and for the practical activities of the disciplines showed that positive results were achieved every time that knowledge produced in different areas were combined. It was, however, clear that it depended on the teacher's decision entirely.

> In the children's health area, we are still able to integrate the portions of the produced knowledge with those produced in the woman's health field; for instance, in the breastfeeding area we bring woman health professionals in […] and we bring the children in. The results were very positive whenever we were able to do that, but […] this is quite an occasional occurrence, it all depends on the desire of the teacher (E16).

Elements that keep children's health education away from the comprehensiveness principle

From the interviewed teachers' perspective, the inclusion of contents into several disciplines causes the fragmentation of the program and does not favor the incorporation of the comprehensiveness principle in the children's health teaching. One of the statements, for example, highlighted that teaching in primary care is *very different, quite disconnected* from teaching in the hospital, and showed that primary care teachers *do not have any contact* with the hospital area.

> We still observe plenty of fragmentation […], we approach the prevention aspect of some diseases […] and you approach hospital care. I just can't see any connection, intersection between contents or even decisions towards the comprehensiveness principle (E2).

> In the discipline 'Women's, Children's and Adolescents' Health I' teaching is based on primary care. The discipline 'Women's, Children's and Adolescents' Health II' is carried out in the hospital […]. They are very different, quite disconnected […]. We don't have any contact with the hospital area (E5).

The lack of dialogue among teachers lead to a repeated appearance of contents, as shown in the following statements:

> For example, the rooming-in practice was the discipline where they [the students] most frequently point to contents appearing repeatedly, because they attend the rooming-in practice in the women's health discipline in the sixth semester and come to the children's healthcare field practice in the seventh semester. They say that they also care for the child in the rooming-in discipline (E4).

The repeated appearance of contents shows, once again, the fragile communication between teachers, resulting from either conceit or fear of losing ground.

> Another issue for the students is this, 'Oh, I have already seen this content in another discipline, I have studied this in that sub-area' […]. I think that we have not yet progressed in this sense. It may be a matter of conceit, because if we integrated everything, we would certainly lose a little ground (E16).

The testimonies also highlighted the persistence of the classical theory/practice binomial, in which the children's health teaching first presents the theoretical contents and only then take students to the field practice.

> In a general sense, we first bring the theoretical content and only then the students attend practical activities. We also propose some exercises. Students have a test, lab classes, before anything else […]. And then they attend training programs (E11).

> They have theoretical classes for one month and only then they attend the practices (E2).

Also with regards to the theoretical and practical teaching, the testimonies showed that the practice of the whole theoretical content is not always guaranteed, as some experiences may not occur in previously programmed field practice.

> Every theory is worked with them in the field practice, except for more serious health events, [as] we just can't assure that a child with that specific disease will show up (E1).

The teachers also pointed out the utter relevance of the reference and counter-reference aspects toward guaranteeing the continuity of the child health care; however, the lack of integration among the health services is quite evident in the teachers' statements, showing that this aspect not only hinders the continuity of the care practice, but also interferes in the teaching practice.

> Now, the discussion of the child care comprehensiveness is sometimes very difficult for us in primary care [teaching]. The reason is the lack of reference organization in the other levels (E12).

Additionally, teachers also show a high level of concern about the length of time the students are kept in the field practice. The following testimony highlights that the practical activities were quite isolated, thus making it hard for the students to be introduced to the healthcare unit and compromising their integration with the healthcare services made available by the unit.

> Our practice is quite isolated. […] We have four practice days. On these days, the groups of students alternate specific care areas. Then, as a matter of fact, they attend one practical class in each area every morning, and that means almost nothing. […] So, they don't have that much time to experience the daily life of the healthcare unit (E15).

DISCUSSION

The reports showed that children's health teaching has been brought closer to the comprehensive care principle in aspects concerning the contents taught, which are guided by governmental child healthcare policies, such as the PAISC, the AIDPI strategy, the Commitment Agenda for Comprehensive Childhood Healthcare and Child Mortality Reduction in addition to the national and local epidemiologic profile focusing on prevalent childhood diseases (diarrhea, malnutrition, anemia and acute respiratory infections).

Additionally, the contents aim to prepare nurses to holistically understand the child within her family and social contexts. All the teachers agreed that the healthcare comprehensiveness principle means to connect the child with broader family and social contexts, which are social determinants of health. Hence, the statements pointed out a conception of comprehensiveness that goes beyond the biological aspects, a perspective in which the child is seen in her totality and where social determinants are taken into account. In this aspect, the testimonies show that children's health teaching standards include the comprehensiveness principle into nurses' education, as verified in a study carried out with teachers in a nursing undergraduate course in the State of Goiás[15].

This critical-reflexive positioning shows a deep concern regarding associating the nursing care with the social determinants of the health-disease process; however, such a standard still needs to be incorporated in the professionals' education. For this purpose, the teaching must take students to understanding that disease events are far more than biological episodes only; the focus of the health

practices should go beyond the disease and address the personal and collective histories of individuals[1,15]. In this context, the home visit strategy brings students closer to the social reality and widens the possibilities of holistically observing the individuals in their realities, thus contributing to the consolidation of their learning processes.

This study did not assess the teacher-student relationship within the practice context; however, for nurse's education to be grounded on the comprehensiveness principle it is crucial that the teacher's practice also incorporate this principle in the caregiving service. From the standpoint of the nursing students, only a few teachers demonstrate in the field practice what is theoretically taught and it

> is only by seeing the efforts and the concerns of the teachers about the patients, doing their best for them and rendering a humanized, comprehensive care, that students will be able to learn and incorporate the comprehensiveness principle in their own practice[16].

Results also showed that the contents addressed multileveled care actions, in accordance with the adopted comprehensiveness reference point. The practical teaching was carried out in the primary care, the hospital area and in other caregiving contexts, such as daycare centers, preschools and schools, thus providing the students with opportunities to develop promotion, prevention and care actions directed to ill children in all different complexity levels of the system, a desirable characteristic toward including the comprehensiveness principle into nurses' education.

Although the practical teaching is distributed in the various care levels of the SUS (national health system), thus favoring the incorporation of the comprehensiveness principle, the reality of the field practice without the presence of a care integrated network opposes the effective teaching of the comprehensiveness principle toward guaranteeing the continuity of a care service that can ensure a comprehensive healthcare to all the needs brought about by the children. A study that assessed the work of nurses in children's hospital discharge processes showed a marked lack of articulation between the hospital and the primary care, resulting in a difficult practice of the comprehensiveness principle[17].

On its turn, the implementation of the practice in different reality contexts, as shown by the results, promotes team work and the integration of future professionals to the reality of the services[1]. Nonetheless, the vast majority of the teachers deemed the length of time of students in the field practice to be very insufficient. They also pointed out that the limited introduction of students into the practical activities of the curriculum allow them neither to experience the daily framework of the services, nor to propose partnered interventions with the service, which stand out as fundamental steps toward the implementation of the comprehensiveness principle.

As a matter of fact, a study that assessed the care comprehensiveness principle based on the conceptions and practices of teachers revealed that the nursing teaching presents occasional, verticalized, uniprofessional and disarticulated pedagogical practices, thus undermining the construction of comprehensiveness and the development of critical, reflexive subjects that will work in the social arena and may transform the organization of the care practices[15].

As for the distribution of children's health contents in the curriculum, it was observed that the contents were addressed in a fragmented way by several disciplines. They were poorly articulated and quite compartmentalized in theoretical and practical segments, a structure that compromises the apprehension of the comprehensiveness principle in the child care and consequently segregates the comprehensiveness principle from nurses' educational development process.

In this aspect, a teacher stated that the primary care teaching was completely distinct from the hospital area teaching, and no contact whatsoever was provided among the teachers. The duplication of contents, referred to several times, highlights how fragile the articulation among the teachers is, being justified as *conceit* or *fear of losing ground*. Thus, it can be observed that each discipline is responsible for teaching a given content, a framework that most often makes it impossible for students to connect the knowledges. Compartmentalized disciplines are built upon a reductionist, fragmented paradigm leading to limited, disjointed contents that will end up influencing the undergraduate health professional's profile and reflect upon his healthcare practices[18].

As shown by this present study, such traditional organization in universities, based on isolated disciplines leading to fragmentation and inducing to the duplication of contents, can be partially justified by the history of the nursing curriculum in Brazil and by the academic background of the teachers on similar curricula[19]. Additionally, it is worth highlighting that the healthcare curricula stems from the recommendations of the Flexner Report, which in the 1940's represented the education model for the healthcare area, focusing on the biological aspects of the care, specialization and hospital care[20].

A study that assessed the comprehensiveness principle in the academic development of nurses, however, evidences that in the perspective of the students, the understanding of the comprehensiveness principle is linked to the articulation among the studied disciplines throughout their educational development and is regarded to the need to correlate the various knowledges throughout the undergraduation period[21]. The assessment of the incorporation of the AIDPI strategy into the professional practice of students who had completed the nursing course confirmed the lack of integration among disciplines, causing the students not to connect important points toward a holistic understanding of the whole picture[22]. The dissemination of fragmented knowledges

centered on contents, even in undergraduate courses with integrating disciplines, was also pointed out by nursing students as being a hindrance to the application of the comprehensiveness principle in nurses' academic development[16]. Therefore, the results highlighted the deconstruction of the fragmented teaching as a relevant challenge[1] toward the inclusion of the comprehensiveness principle in children's health teaching in the nursing educational curriculum.

Another aspect that generates a gap between the teaching of the comprehensiveness principle and the nursing curriculum is that introducing the student to field practices occurs only after the theoretical teaching, thus indicating that the field is used to practice theoretical knowledge and not as a means for the student to gather experience and know-how toward acquiring skills that will help him or her to work in child healthcare.

The theory-practice integration is a fundamental step in the learning process; yet, such integration has to take place in the field practice and not by a process in which the practice only seeks to prove the patterns established by the theory. In order to overcome that challenge, pedagogical actions must keep the balance between theory and practice toward the construction of competences that encourage both teachers and students to search for new knowledges that can respond to the issues posed by the practice. These actions must point to the principle in which the learning process starts with the practice, so that students are able to perform activities and perform them again, whenever necessary. Therefore, the educational development process must prepare subjects to learn how to carry out their work based on experience, so they are able to cope with the new demands of society and work toward transforming the current situation[15].

A study that assessed the nursing teacher-student relationship, as well as the problems generated by the academic development for the SUS (national health system), confirmed that, in addition to the fragmentation of contents in the disciplines, the dichotomy between theory and practice contributed to the segregation of the comprehensiveness principle in the care practice. The students pointed out the need to reorganize the course, as they believed that the *learn-perform* framework was the path to be followed toward changing the theory-based teaching process, which was incoherently articulated with the practice and counted on a low level of engagement on the part of the students[23].

This context also highlights that the comprehensiveness principle is built in the daily relationship established in the academic development process. In the perspective of the students, the comprehensiveness principle must permeate the teacher-student relationship in the same way that the clients in the health system must be considered as a whole being from social, political and economic contexts, not fragmented into pieces. Thus, students must also be respected as a subject of an educational process that prioritizes the opening of dialogues and that allows him or her to get closer to reality by having their life history, distresses and feelings taken into account[16].

As such, new forms of integration must be elaborated between the practical services and the educational environments, thus generating spaces for reflection on the teaching and the learn-by-doing processes. It is expected that students increasingly get closer to real practical spaces, so that they can truly contribute to the transformation of care practices and to the improvement of the health status of the children. For that to happen, any teaching that enables a limited and fragmented healthcare must be reviewed[24]. The teaching-service integration stands out as an ideal to be pursued toward the proposition of the construction of an integrated curriculum in which theory and practice are inseparable[25].

Such integration is not an easy task, as shown by the testimonies in this present study. The nursing healthcare still walks side by side with the need to transform the concepts and practices that guide the current healthcare professionals' educational development, as the comprehensive aspect of the care service must be an efficient part of both the teaching and the field practice[6]. In this context, the results of this present study showed that nurses' educational development still represents a great challenge concerning the comprehensiveness perspective in children's health.

CONCLUSION

The present study aimed to assess the incorporatioof the comprehensiveness principle in children's health throughout the nursing undergraduate course from teachers' perspective.

The results showed points of convergence and divergence between the children's health teaching and the comprehensive principle. In the aspects related to the theoretical contents, the children's health teaching incorporates the comprehensiveness principle in the academic development of nurses, based on the policies and programs toward child healthcare, including promotion, prevention and care actions to ill children in the various field practices made available by healthcare units, hospitals, daycare centers and preschools.

However, the curriculum is organized in disciplines in which theory and practice are not integrated. There is no articulation among the various disciplines, or among the teaching institutions and the healthcare services. The introduction of students into field practice occurs only after theoretical teaching is carried out, and it follows quite a limited pattern, a fact that hinders the

integration between theory/practice in the daily service activities with social contexts. Despite the broadened conception of the health-disease process, which enables the comprehension of children within their family and community, there is a clear contradiction between the propositions and the practice. The teaching is still quite fragmented and compromises the apprehension of a holistic approach of the childcare needs that is so crucial to the comprehensive principle.

In summary, the various notions of the comprehensiveness principle are present in the studied context; yet, besides the convergences, the pedagogical practice does not favor the incorporation of the comprehensiveness principle in the children's health teaching. The lack of integration among disciplines and articulation among teaching institutions and health services show a long way before the comprehensiveness principle can finally by incorporated in the nursing education.

REFERENCES

1. Gonzalez AD, Almeida MJ. Integralidade da saúde: norteando mudanças na graduação dos novos profissionais. Ciênc Saúde Coletiva. 2010;15(3):757-62.

2. Paim JS. Desafios para a saúde coletiva no Século XXI. Salvador: EDUFBA; 2007.

3. Brasil. Lei n. 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências [Internet]. Brasília; 1990 [citado 2013 set. 17]. Disponível em: http://www.planalto.gov.br/ccivil_03/Leis/L8080.htm

4. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Pinheiro R. Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: UERJ;IMS/ABRASCO; 2006. p. 41-66.

5. Gonze GG, Silva GA. A integralidade na formação dos profissionais de saúde: tecendo valores. Physis Rev Saúde Coletiva. 2011;21(1):129-46.

6. Ceccim RB, Feuerwerker LCM. Mudança na graduação das profissões de saúde sob o eixo da integralidade. Cad Saúde Pública. 2004;20(5):1400-10.

7. Pettengill MAM, Nunes CB, Barbosa MAM. Professor e aluno compartilhando da experiência de ensino-aprendizagem: a disciplina de enfermagem pediátrica da Universidade Federal de Mato Grosso do Sul. Rev Latino Am Enferm. 2003;11(4):453-60.

8. Rocha SMM, Lima RAG, Scochi CGS. Assistência integral à saúde da criança no Brasil: implicações para o ensino e a prática da enfermagem pediátrica. Saúde Soc. 1997;6(1):25-52.

9. Prado SRLA, Fujimori E, Cianciarullo TI. A prática da integralidade em modelos assistenciais distintos: estudo de caso a partir da saúde da criança. Texto Contexto Enferm. 2007;16(3):399-407.

10. Alves CRL, Lasmar LMLBF, Goulart LMHF, Alvim CG, Maciel GVR, Viana MRA, et al. Qualidade do preenchimento da Caderneta de Saúde da Criança e fatores associados. Cad Saúde Pública. 2009;25(3):583-95.

11. Silva ACMA, Villar MAM, Wuillaume SM, Cardoso MHCA. Perspectivas de médicos do Programa Saúde da Família acerca das linhas de cuidado propostas pela Agenda de Compromissos para a Saúde Integral da Criança e Redução da Mortalidade Infantil. Cad Saúde Pública. 2009;25(2):349-58.

12. Cursino EG, Fujimori E. Integralidade como uma dimensão das práticas de atenção à saúde da criança: uma revisão bibliográfica. Rev Enferm UERJ. 2012;20(n.esp.1): 676-80.

13. Cursino EG, Fujimori E, Gaíva MAM. Integralidade no ensino da saúde da criança na graduação em enfermagem: análise de planos de ensino. Ciênc Cuid Saúde. 2012; 11(4):799-807.

14. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2010.

15. Santana FR, Nakatani AYK, Freitas RAMM, Souza ACS, Bachion MM. Integralidade do cuidado: concepções e práticas de docentes de graduação em enfermagem do Estado de Goiás. Ciênc Saúde Coletiva. 2010;15 Supl. 1:1653-64.

16. Lima MM, Reibnitz KS, Prado ML, Kloh D. Integralidade como princípio pedagógico na formação do enfermeiro. Texto Contexto Enferm. 2013;22(1):106-13.

17. Silva RVGO, Ramos FRS. O trabalho de enfermagem na alta de crianças hospitalizadas: articulação da atenção hospitalar e básica. Rev Gaúcha Enferm. 2011;32(2):309-15.

18. Saippa-Oliveira G, Koifman L, Pinheiro R. Seleção de conteúdos, ensino-aprendizagem e currículo na formação em saúde. In: Pinheiro R, Ceccim RB, Mattos RA, organizadores. Ensinar saúde: a integralidade e o SUS nos cursos de graduação na área da saúde. Rio de Janeiro: IMS/UERJ/ABRASCO; 2006. p. 205-28.

19. Tavares CMM. Integração curricular no curso de Graduação de Enfermagem. Rev Bras Enferm. 2003;56(4):401-4.

20. Carvalho YM, Ceccim RB. Formação e educação em saúde: aprendizados com a saúde coletiva. In: Campos GWS, Minayo MCS, Akerman M, Drumond Junior M, Carvalho YM, organizadores. Tratado de saúde coletiva. 2ª ed. São Paulo: Hucitec; 2010. p. 137-86.

21. Rebouças LCC. A integralidade do cuidado na formação da enfermeira [dissertação]. Salvador: Escola de Enfermagem, Universidade Federal da Bahia; 2007.

22. Higuchi CH, Fujimori E, Cursino EG, Chiesa AM, Veríssimo MDLÓR, Mello DF. Atenção integrada às doenças prevalentes na infância (AIDPI) na prática de enfermeiros egressos da USP. Rev Gaúcha Enferm. 2011;32(2):241-7.

23. Moretti ORP, Bueno SMV. Relação docente-discente em enfermagem e problemas na formação para o Sistema Único de Saúde. Acta Paul Enferm. 2009;22(5):645-51.

24. Montenegro LC, Penna CMM, Brito MJM. Comprehensive care from the perspective of health care workers from Belo Horizonte. Rev Esc Enferm USP [Internet]. 2010 [cited 2013 Sept 17];44(3):649-56. Available from: http://www.scielo.br/pdf/reeusp/v44n3/en_14.pdf

25. Tanji S, Silva CMSLMD, Albuquerque VS, Viana LO, Santos NMP. Integração ensino-trabalho-cidadania na formação de enfermeiros. Rev Gaúcha Enferm. 2010;31(3):483-90.

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