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HEALTH EDUCATION IN THE CONTEXT OF CHEMOTHERAPY: NURSES' PERCEPTION

Educação em saúde no contexto da quimioterapia: percepção de enfermeiras

Educación en salud en el contexto de quimioterapia: percepción de las enfermeras

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RESUMO

Objetivo: descrever as percepções de enfermeiras na realização de ações de educação em saúde durante a quimioterapia. **Método:** estudo qualitativo realizado com oito enfermeiras de dois serviços de quimioterapia de Pernambuco, Brasil. Foram realizadas entrevistas gravadas entre abril e junho de 2021. Os dados foram transcritos, validados e analisados por análise de conteúdo com base na Política Nacional de Educação Popular em Saúde. **Resultados:** emergiram quatro categorias: 1- O discurso do enfermeiro e a compreensão das informações pelo paciente; 2- Consulta de Enfermagem como facilitadora da educação em saúde na quimioterapia; 3- Sentimento e comportamento do enfermeiro na realização das ações educativas; 4- O conhecimento do paciente como elemento positivo para assistência de enfermagem. **Considerações finais:** as percepções relacionam-se a práticas que priorizam o acolhimento, o diálogo claro e as necessidades da pessoa, favorecendo uma relação de confiança, troca de informações e cuidado afetuoso e disponível à pessoa com câncer.

DESCRITORES: Educação em saúde; Enfermagem; Enfermagem oncológica; Antineoplásicos.

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ABSTRACT

Objective: to describe nurses' perceptions when carrying out health education actions during chemotherapy. **Method:** qualitative study carried out with eight nurses from two chemotherapy services in Pernambuco, Brazil. Recorded interviews were conducted between April and June 2021. Data were transcribed, validated, and analyzed by content analysis based on the National Policy for Popular Health Education. **Results:** four categories emerged: 1- Nurses' discourse and patient understanding of information; 2- Nursing consultation as a facilitator of health education in chemotherapy; 3- Nurses' feelings and behavior when carrying out educational actions; 4- Patient knowledge as a positive element for nursing care. **Final considerations:** perceptions are related to practices that prioritize welcoming, clear dialogue, and the person's needs, favoring a relationship of trust, exchange of information, and affectionate and available care for the person with cancer.

DESCRIPTORS: Health education; Nursing; Oncology nursing; Antineoplastic agents.

RESUMEN

Objetivo:d las percepciones de los enfermeros al realizar acciones de educación en salud durante la quimioterapia. **Método:** estudio cualitativo realizado con ocho enfermeros de dos servicios de quimioterapia de Pernambuco, Brasil. Las entrevistas grabadas se realizaron entre abril y junio de 2021. Los datos fueron transcritos, validados y analizados mediante análisis de contenido con base en la Política Nacional de Educación Popular en Salud. **Resultados:** emergieron cuatro categorías: 1- El discurso del enfermero y la comprensión de la información por parte del paciente; 2- Consulta de enfermería como facilitadora de educación para la salud en quimioterapia; 3- Sentimientos y comportamiento del enfermero en la realización de acciones educativas; 4- El conocimiento del paciente como elemento positivo para los cuidados de enfermería. **Consideraciones finales:** las percepciones se relacionan con prácticas que priorizan la acogida, el diálogo claro y las necesidades de la persona, favoreciendo una relación de confianza, el intercambio de información y un cuidado afectuoso y disponible para la persona con cáncer.

DESCRIPTORES: Educación para la salud; Enfermería; Enfermería oncológica; Antineoplásicos.

INTRODUCTION

Cancer is considered the main public health problem in the world and is one of the main reasons for death before the age of 70. Its incidence and mortality have been gradually increasing according to the risk factors for the disease to which the population is exposed. The National Cancer Institute (INCA) has also estimated that, in Brazil, there will be 704,000 new cases each year during the three-year period 2023-2025.[1] Interventions for individuals diagnosed with neoplasms range from surgical and non-surgical treatments, with chemotherapy being one of the most widely used alternatives in the fight against the disease.[1,2]

Chemotherapy is carried out through the administration of antineoplastic drugs which have a systemic action and, despite their benefits for this disease, can result in various adverse effects, which requires more specific care [2]. In this context, chemotherapy treatment is challenging, as it physically affects the patient with changes in appearance, such as alopecia, constipation, stomatitis, nausea, vomiting, pain, among others. It can also have repercussions on the person's psychosocial identity, as it causes changes in their family dynamics and social relationships.[3,4]

All these changes require specialized attention from health professionals, so that the individual experiencing this moment receives the necessary guidance on the disease, treatment and prognosis, with a view to better therapeutic adherence for their well-being[5,6]. Nursing professionals stand out not only in providing care for people undergoing chemotherapy, but also in health education. Nurses have a fundamental role to play in developing guidance on treatment, making it clear and effective throughout the course of action in order to minimize problems and complications and offer autonomy for care.[7,8,9]

The integration of educational technologies that embrace people's individualities in the development of health education, as well as supporting nurses' professional practice, expands strategies and makes the person with cancer the protagonist of care, since they will share their experience and receive the attention and instruction required for their needs.[7]

Considering the prevalence of cancer in the world population, the importance of this issue for today's society and the contribution that knowledge of health education interventions aimed at people undergoing chemotherapy can make, further studies are needed to evaluate the adoption of these actions by nurses. In this way, knowledge of nurses'

perceptions of health education contributes to improving the quality of life of people who are going through chemotherapy. This study aims to describe nurses' perceptions of health education during chemotherapy treatment.

METHOD

This was a descriptive study with a qualitative approach, guided by the following question: "How do nurses perceive health education practices during chemotherapy treatment?". The research was carried out in a municipality in the Agreste region of the state of Pernambuco, Brazil, which is a reference for cancer treatment with chemotherapy. Eight nurses who work in two outpatient chemotherapy units that are a reference for regional health departments in cancer treatment took part in the study between April and June 2021. There were no losses or refusals to participate in the sample.

The participants were selected through saturation sampling[8], respecting the following eligibility criteria: nurses who work in chemotherapy administration centers and who had more than one year's experience in the unit were included. Nurses who worked in other areas/specialties concurrently with their work in oncology were excluded. Saturation was defined as the moment at which the participants' reports converged in relation to their core meanings for the questions listed.

To collect the data, the professionals received an invitation from the researchers informing them of the research objectives and procedures. Upon acceptance, the participants were presented with the Free and Informed Consent Form (FICF) to sign and the participants were directed to a room provided by the service, where their privacy and confidentiality regarding the information collected was guaranteed.

Data collection took place through a semi-structured interview, prepared by the researchers, divided into two parts: the first raised questions to characterize the nurses' profile and the second questions related to the objectives proposed by the study, namely: 1- How do you carry out health education activities in your work routine? 2- In your opinion, what is the best time to carry out health education activities for patients undergoing chemotherapy? Why?; 3- What strategies do you use to carry out health education activities for patients undergoing chemotherapy?; 4- How do you feel about carrying out health education activities for patients undergoing chemotherapy?; 5- Do you believe that health education activities help with chemotherapy treatment? Why?

The answers to the questions were recorded using a Knup Mp3 Kp-8004 voice recorder and later transcribed in a reliable manner and stored in a database by the researchers. The recorded reports contained a record of the nurses' desire to take part in the research. After the interviews, which lasted an average of ten minutes each, the statements were transcribed and given to the participants to validate their answers and use in this research. Field notes were also taken during the interview.

Due to the Coronavirus (COVID-19) pandemic, it was necessary to follow safety guidelines through the application of social distancing between the participants and the researchers during the interview, the use of personal protective equipment (face mask), since the collection took place in person, conducted by three undergraduate nursing students, trained to carry out data collection and by a professor with a doctoral degree and expertise in conducting interviews to obtain qualitative data.

In order to preserve the names of the research participants, the term "ENF" was used, associated with the cardinal number 1-8, according to the order in which the interview took place (e.g. ENF 1). The answers were organized into thematic categories based on the core meaning of the nurses' reports, which were obtained from a critical reading of the textual corpus derived from the transcription of the interviews.

The data was analyzed using the Content Analysis[9] technique, through which categories and subcategories were extracted from the textual corpus. The data from the analysis was interpreted in the light of the guiding principles of the National Policy for Popular Education in Health of the Unified Health System (PNEP-SUS), standardized through Ordinance No. 2761 of 2013.[10]

The Consolidated criteria for reporting qualitative research (COREQ) methodological guide was used to adapt the necessary components in the construction and description of qualitative research, a tool that enables greater methodological rigor and the approach of fundamental aspects that must be considered in the preparation of the study, reverberating in the credibility and consolidation of the data exposed.[11]

The research was carried out after it was approved by the Research Ethics Committee (CEP) under opinion no. 4. 586. 391 and CAAE 44028621.0.0000.5203, in compliance with the resolutions and standards for research involving human beings set out in Resolution 466/2012 of the National Health Council.

RESULTS

The survey participants were all female and of these, five (62.5%) were aged between 24 and 27 and three (37.5%) between 37 and 50. With regard to specialization, three had specialization in oncology, two were in the process of specializing in the area and three reported specialization in

different areas. Training time ranged from two to 27 years and experience ranged from one to 18 years. The following categories emerged from the analysis of the core meanings of the transcribed reports:

CATEGORY 1 - The nurse's discourse and the patient's understanding of the information

This category emerges from the discourse of the professionals related to the difficulty of establishing comprehensible communication with the patient in the face of complex care. Popular myths and the time it takes to carry out health education actions are seen as obstacles to the development of satisfactory communication aimed at a real understanding of the information related to the care provided.

The patient has contact with the nursing staff, not just the doctor. Many of them take the treatment without asking any questions. So at that moment of contact with the nurse, I'm going to cover everything I can. See what social conditions this patient has, if they're able to understand what I'm going to say. (ENF 4)

The neighbor said this, said that and the nurse's information is left out. (NURS 7)

Unfortunately, time is short, but I ask them to tell me their main fear and doubt when they speak. (ENF 5)

It's a lot! It's very difficult to do orientation when it's a first-time patient. (ENF 8)

Sometimes there are patients who are embarrassed to ask questions, don't understand the information or understand it differently. (ENF 1)

CATEGORY 2 - Patient knowledge as a positive element for nursing care.

The professionals emphasize the establishment of a bond of trust with the patient through health education actions and that these are a facilitating element for adherence, reducing abandonment and understanding the reactions experienced during chemotherapy.

Patients can give up on treatment because of this (doubts) because they'll think it's something very different that's happening and give up. So from the moment they know that it can happen and that it's expected, they feel calmer and contribute to the nursing care. (ENF 1)

When you know everything that's going to happen, all the processes are much more comfortable, because you already know what to expect. (NUR 3)

The patient feels safer because they already know everything that's going to happen, they're aware of what can and can't happen, what's expected because in cancer treatment there can be many changes. (ENF 6)

Knowledge is good for everything, it only brings benefits! It's very important when you know what you're doing, what they're doing to you. It's not just installing the serum and letting it happen. (ENF 5)

CATEGORY 3 - Nursing consultation as a facilitator of health education during chemotherapy

This category emerges from the need for the patient to have an individualized moment with the nurse so that the latter can work on health education actions related to chemotherapy. Nurses understand the importance of the consultation, but come up against administrative issues in the health services that compromise the development of individualized, quality nursing care, especially in health education.

The ideal time for health education would be during a nursing visit before the patient starts treatment. That we had the opportunity to talk to the patient, to do all the orientation individually without being in the room with other people. (ENF 6)

We talk in person and on the phone, which always rings on weekends, holidays, etc. It's also important to highlight the need for health education actions by professionals, either due to the lack of organization on the part of the team or due to obstacles in the institutions which mean that educational strategies are scarce. It is also important that the nursing consultation is included in the patient's therapeutic plan, as it is at this individualized moment that the patient's demands will be heard and subsequently met. The ideal time for health education would be during the nursing consultation. We're trying to implement a screening and consultation process, at which point we can provide guidance. (ENF 8)

We find it difficult to carry out health education because we don't have the room to carry out nursing consultations and guide patients properly, but every time they start chemotherapy we advise them on the importance of healthy habits, the use of antiemetic medication and answer any questions they may have. (ENF 1)

We would have more time to deal with patients' complaints, answer their questions and they would feel more at ease. A real nursing consultation would be more interesting at this time, but at the moment, as this isn't the reality of the service, we try to adapt by doing it in the chemotherapy room itself. (NURS 3)

So nursing needs to be asked to make this first contact and in some services this doesn't exist. The nursing office is lacking. (ENF 2)

CATEGORY 4 - Nurses' feelings and behavior when carrying out health education activities

Professionals' feelings when carrying out health education are of responsibility, zeal and compassion for the patient undergoing treatment. It can be seen that care goes beyond the procedural and involves ethical relationships, affection and commitment to the impacts that can occur when caring for patients undergoing chemotherapy.

> *Health education certainly helps with chemotherapy treatment. Because knowledge is good for everything, it only brings benefits. It's very important when you know what you're doing, what they're doing to you, not just putting it there and letting it happen. (ENF3)*

> *The majority of patients are already very grateful, so we see the good results of health education not only in chemotherapy treatment, but in the treatment of any pathology, because no one is obliged to know everything. (ENF 8)*

> *Health education in chemotherapy is positive because when we don't believe in what we're doing and what we're imposing, we're being hypocritical. If I'm doing what I'm doing, it's because I think it's going to have a result and that it's going to be good.(ENF 2)*

> *We have to have the ability to pass on knowledge and insist that patients really improve in this area, because it will be good for them. (ENF 1)*

DISCUSSION

The PNEP-SUS development proposal is based on the development of a health system that allows its users to manage their health problems and develop, in partnership with professionals and services, their skills based on problematization, for a shared and critical construction of knowledge, and that this knowledge, attitudes and practices are based on dialogue, lovingness and that they are a vehicle for emancipation and commitment to the construction of the People's Democratic Project.[10,12]

Understanding oneself as a cancer patient and immersing oneself in a reality of complex, sometimes mutilating treatments that are culturally associated with death and suffering brings a load of feelings and impressions that are reinforced when starting treatment with chemotherapy, where the universe of the health service becomes a new obstacle to be understood and overcome for a better outcome.[13]

The nurses' difficulty in communicating with patients was noticeable, especially in the face of sociocultural issues, which led to impasses during treatment and highlighted the need for individual moments between patient and professional to establish a dialog focused on the individuality of the person. Dialogue is the meeting of knowledge constructed historically and culturally by subjects, in other words, the meeting of these subjects in intersubjectivity, which happens when each one, in a respectful way, makes what they know available to broaden their critical knowledge of reality, contributing to the processes of transformation and humanization. Nursing care must go beyond the procedural act and transfer affection and commitment, making it possible to create a bond of trust, which is an enabler of health education actions as a strategy that is inserted into the daily life of people with cancer.[7,10,14]

In patient counseling, communication difficulties can exist due to cultural influence, where there may be rites, beliefs, spirituality, religiosity or taboos that can cause some setback during counseling and become an obstacle in the treatment process.[15] The communication relationship between nurse and patient, in the therapeutic context, is used as a facilitator of this process, and can influence both the development and quality of treatment, as the patient feels more confident to report their perceptions and knowledge to the professional. The work carried out by the nurse enhances the conditions for the person to be able to respond, in a positive and shared way, to the adversities arising from the process of illness and treatment.[14,16]

The nurses' reports highlight the patients' relationship of belonging to the treatment and their need to know more about this process in order to better experience and cope with it. They are also willing to clarify the essential aspects so that the patient feels appropriate and is an active participant in the construction of knowledge, creating a kind of sharing of impressions and experiences (on the part of the patient) with the robustness of the technical information facilitated (by the nurse). The shared construction of knowledge consists of communicational and pedagogical processes between people and groups with different knowledge, cultures and social backgrounds, with a view to collectively understanding and transforming health actions from their theoretical, political and practical dimensions.[10,17]

Problematization, highlighted as fundamental in the PNEP-SUS, is an element practiced by nurses with patients during chemotherapy, establishing dialogic relationships and proposing the construction of health practices based on the reading and critical analysis of reality.[10] The reports clearly show that a relationship of exchange is established and that this is essential for coping positively, building knowledge and strengthening the care offered during chemotherapy cycles.

Outpatient cancer care environments are thought of from a biologicist perspective, i.e. focused on spaces where the user will

enter the service with the sole aim of receiving chemotherapy and the care related to this intervention. To think about health education is to understand that its practice requires spaces for listening, exchanging experiences and forming a critical sense about health experiences, and that these spaces are elements that make up the treatment of people with cancer.[10,14]

One of the ways in which health education can be carried out in an individualized way is in the nursing consultation, which was mentioned in the reports and supported in the literature as an essential tool for continuity of care, which works on the particularities of the patient, since, from this meeting, it is possible to build strategies in relation to the person's reality, in a way that contributes to controlling the symptoms and adverse effects of chemotherapy, as well as making it possible to inspect the biopsychosocial and spiritual conditions that influence this process [16]. Nursing consultations before chemotherapy infusions and health education during treatment optimize the patient's time in the service and give them a leading role, as they provide knowledge about care, the drugs administered and specific adverse effects.[7,18]

On the other hand, as evidenced by the nurses' statements, the administrative issues of the services often become an obstacle to the development of the nursing process. It has been argued that too much bureaucracy, resistance to the application of new methodologies, an exorbitant workload and nursing attributions and poor sizing of the team and patients, compromise the planning and implementation of care in an efficient and effective manner.[19] Some studies show that the daily work of nurses in oncology permeates challenging issues, situations and demands, also bringing feelings of anguish, uncertainty and the constant need for resignification. Nursing teams in oncology units also state that carrying out their activities requires a high level of responsibility and workload, consequently generating a high emotional overload.[20]

The majority of nurses who work in oncology care have an attitude profile based on values such as strength, sensitivity, empathy, patience, the ability to welcome, support and offer comfort to patients and their families, but they must be able to provide care in such a way as to separate their personal and work lives, respecting ethics and preventing psychological suffering in everyday scenarios.[19] The bond of trust generated by professionals who are attentive and show empathy for their patients minimizes setbacks and strengthens coping with the disease, due to the more humanized care, enhancing conditions so that patients can respond positively to the adversities arising from the disease and treatment process.[16]

Loving kindness is an element highlighted in the nurses' reports when they refer to health education interventions as situations that can benefit the patient and that this result strengthens their feelings and perceptions about their professional practice. Loving kindness is understood as the expansion of dialogue in care relationships and in educational action through the incorporation of emotional exchanges and sensitivity, allowing us to go beyond dialogue based only on knowledge and logically organized arguments.[21]

Studies also show that the relationship between nurses and cancer patients fosters feelings of concern, affection and willingness towards each other, corroborating effective guidance, education and care actions.[14,22] It is essential to build up the skills required of health professionals, namely: knowing how to be, which refers to attitudes based on values and principles; knowing how to live together, which refers to coexistence; knowing how to know, which is related to theoretical and scientific knowledge; and knowing how to do, which is the set of skills that enable practice to be applied effectively and beneficially.[19] Although the affection between professional and patient must also set limits, avoiding the risk of projecting suffering onto oneself, mixing up feelings, because excessive attachment can become a factor of suffering, exceeding limits, causing uncomfortable situations and confusing professional and personal life.[23]

The limitations of the study are related to the sample of professionals interviewed, which may have compromised a greater use of the speeches and their core of meaning. Another complicating factor was the fact that these professionals were released from the health service to carry out the interviews, which made it difficult for the participants to elaborate their reasoning and may have compromised the detail of the interviews.

This study represents a small part of the research still needed on the subject. The prospects for future studies and contributions to practice are to present new data that point to the need for health education with cancer patients undergoing chemotherapy, exposing the scenarios of how this assistance is developed, as well as the lack or effective presence of nursing interventions and their relevance within the chemotherapy context.

FINAL CONSIDERATIONS

The nurses' perceptions of health education during chemotherapy treatment are related to welcoming the person with cancer (respecting their culture, practices and previous knowledge as elements that contribute to care), establishing a clear, precise dialog focused on the needs of each person, establishing a relationship of trust and exchange of information

and feelings of concern, affection and availability to care for the person with cancer.

The health education practices developed during chemotherapy and reported are directly related to the PNEP-SUS and are seen as contributing to the process of building autonomy and self-care throughout treatment. Among the obstacles to associating these actions with the policy is the contingent of planning and management that do not articulate the practice of health education as an element present in care and which promotes benefits for all the actors involved.

The study contributes to professional practice by allowing us to understand the aspects related to health education interventions from the nurses' perspective and by explaining elements that, when thought about, can confer benefits to chemotherapy treatment and positive outcomes in oncology care that go beyond the procedural relationship and are part of the contingent of relationships between professionals and patients, in the strategic thinking of service management in fostering clinical practice spaces that allow the insertion of health education and in professional motivation for caring associated with educating.

REFERENCES

1. Instituto Nacional do Câncer José de Alencar Gomes da Silva. Estimativa 2023: incidência do câncer no Brasil [internet}. Instituto Nacional do Câncer José de Alencar Gomes da Silva, 2022 [acesso em 23 de novembro 2023]. Disponível em: https://www.inca.gov.br/sites/ufu.sti.inca.local/files//media/document//estimativa-2023.pdf.
2. Bonassa EMA, Gato MIR, Rodrigues LA. Terapêutica Oncológica para Enfermeiros e Farmacêuticos. São Paulo: Atheneu; 2023.
3. Captein KM, Simão DAS, Aguiar ANA, Pena ED, Souza RAS, Mendoza IYQ. Educational actions in the daily life of oncological nursing: Integration Review. Rev Enferm. UFPE on line [internet]. 2017 [cited 2023 nov 02];11(2). Available from: http://doi.org/10.5205/reuol.10263-91568-1-RV.1102sup201716.
4. Reis DLA, Santos SMA, Kietzer KS. Tecnologia educacional em saúde para pacientes em tratamento quimioterápico ambulatorial. Interdisciplinary Journal of Health Education [internet]. 2017 [acesso em 23 de novembro 2023];2(2). Disponível em: http://doi.org/10.4322/ijhe.2017.005.
5. International Agency for Reseach on Cancer. World Cancer Report – Cancer research for cancer prevention [internet]. International Agency for Reseach on Cancer. [Internet]. 2020 [cited 2023 nov 02]. Available from: https://publications.iarc.fr/Non-Series-Publications/World-Cancer-Reports/World-Cancer-Report-Cancer-Research-For-Cancer-Prevention-2020.
6. Silva LR, Almeida CAPL, Sá GGM, Moura LKB, Araujo ETH. Educação em saúde como estratégia de prevenção do câncer do colo do útero: revisão integrativa. REPIS [internet]. 2017 [acesso em 2 de novembro 2023];3(4). Disponível em: http://www.ojs.ufpi.br/index.php/nupcis/article/view/6708.
7. Silva LCA, Signor AC, Pilati ACL, Dalfollo BR, Oliveira DR. Abordagem Educativa ao Paciente Oncológico: Estratégias para Orientação acerca do Tratamento Quimioterápico. Rev Bras Cancerol. [internet]. 2019 [acesso em 2 de novembro 2023];65(1):e-06305. Disponível em: https://rbc.inca.gov.br/index.php/revista/article/view/305.
8. Moura CO, Silva IR, Silva TP, Santos KA, Crespo MCA, Silva MM. Percurso metodológico para alcance do grau de saturação na pesquisa qualitativa: teoria fundamentada. Rev Bras Enferm [internet]. 2021 [acesso em 9 de março 2025];75(2):e20201379. Disponível em: https://doi.org/10.1590/0034-7167-2020-1379.
9. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2016.
10. BRASIL. Portaria nº 2.761, DE 19 DE NOVEMBRO DE 2013. Institui a Política Nacional de Educação Popular em Saúde no âmbito do Sistema Único de Saúde (PNEPS-SUS). Ministério da Saúde, 2013. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt2761_19_11_2013.html.
11. 11.Souza VR, Marziale MH, Silva GT, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm. [internet]. 2021 [acesso em 2 de novembro 2023];34:eAPE02631. Disponível em: https://doi.org/10.37689/acta-ape/2021AO02631.
12. Pedrosa JIS. A Política Nacional de Educação Popular em Saúde em debate: (re) conhecendo saberes e lutas para a produção da Saúde Coletiva. Interfaces. [internet]. 2021 [acesso em 9 de março 2025];25(1). Disponível em: https://doi.org/10.1590/Interface.200190.
13. Antunes RF, Dib RV, Ramos RS, Gomes AMT, Santos MM, Bernardes MMR, Santos CCS, Souza KPDS. Representações sociais da cirurgia oncológica para o paciente com câncer. Rev Bras Enferm. [internet]. 2024 [acesso em 9 de março 2025];77(6):e20230273. Disponível em: https://doi.org/10.1590/0034-7167-2023-0273pt.
14. Theobald MR, Santos MLM, Andrade SMO, de-Carli AD. Percepções do paciente oncológico sobre o

cuidado. Physis. [internet]. 2016 [acesso em 9 de março 2025];26(4). Disponível em: https://doi.org/10.1590/S0103-73312016000400010.

15. Fornazari SA, Ferreira RER. Religiosidade/espiritualidade em pacientes oncológicos: qualidade de vida e saúde. Psic. Teor e Pesq. [internet]. 2010 [acesso em 9 de março 2025];26(2). Disponível em: https://doi.org/10.1590/S0102-37722010000200008.

16. 16.Oliveira JM, Reis JB, Silva RA. Search for oncological care: Perceptions of patients and family members. Rev enferm UFPE online. [internet]. 2018 [cited 2023 nov 02];12(4). Available from: https://doi.org/10.5205/1981-8963-v12i4a231359p938-946-2018.

17. Cruz PJSC, Silva JC, Danielski K, Brito PNA. Educação popular em saúde: princípios, desafios e perspectivas na reconstrução crítica do país. Interface. [internet]. 2024 [acesso em 9 de março 2025];28(8). Disponível em: https://doi.org/10.1590/interface.230550.

18. Tolentino GS, Bettencourt ARC, Fonseca SM. Construção e validação de instrumento para consulta de enfermagem em quimioterapia ambulatorial. Rev Bras Enferm. [internet]. 2019 [acesso em 9 de março 2025];72(2). Disponível em: http://dx.doi.org/10.1590/0034-7167-2018-0031.

19. Carmo RALO, Siman AG, Matos RA, Mendonça ET. Cuidar em Oncologia: Desafios e Superações Cotidianas Vivenciados por Enfermeiros. Rev Bras Cancerol. [internet]. 2019 [acesso em 2 de novembro 2024];65(3):e-14818. Disponível em: https://doi.org/10.32635/2176-9745.RBC.2019v65n3.818.

20. Lazzaroto PK, Celich KLS, Souza SS, Léo MMF, Silva TG, Zenevicz LT. Estratégias de enfrentamento utilizadas pela equipe de enfermagem no cuidado ao paciente oncológico e família. Rev Enferm UFSM [internet]. 2018 [acesso em 2 de novembro 2023];8(3). Disponível em: https://doi.org/10.5902/2179769229408.

21. Paro CA, Lemões MAM, Pekelman R. Coletânea Educação Popular em Saúde Volume 2: Educação Popular e a (re)construção de práticas cuidadoras. João Pessoa: Editora do CCTA; 2020.

22. Kolls M, Machri E, Ferri G, Brustolin A, Bocca M. Sentimentos de Enfermeiros Frente ao Paciente Oncológico. J Health Sci. [internet].2016 [acesso em 9 de março 2025];18(4). Disponível em: https://doi.org/10.17921/2447-8938.2016v18n4p245-50.

23. Bubolz BK, Barboza MCN, Amaral DED, Viegas AC, Bernardes LS, Muniz RM. Percepções dos Profissionais da Enfermagem a Respeito do Sofrimento e das Estratégias de Enfrentamento na Oncologia. Rev Fund Care Online. [internet]. 2019 [acesso em 2 de novembro 2023];11(3). Disponível em: http://doi.org/10.9789/2175-5361.2019.v11i3.599-606.