RESEARCH

PEDIATRIC HEALTH CARE: PRACTICE OF NURSES IN THE FAMILY HEALTH PROGRAM

ATENÇÃO À SAÚDE DA CRIANÇA: PRÁTICA DE ENFERMEIROS DA SAÚDE DA FAMÍLIA

ATENCIÓN DE LA SALUD INFANTIL: PRÁCTICA DE LOS ENFERMEROS DE SALUD DE LA FAMILIA

Rosana Santana de Souza [1]
Rosângela Aparecida Pimenta Ferrari [2]
Tabatha de Freitas Moreira Santos [1]
Mauren Teresa Grubisdich Mendes Tacla [3]

[1] Nurse. Department of Public Health, Health Science Center, State University of Londrina (UEL). Londrina, PR – Brazil.
[2] Nurse. Adjunct Professor and Coordinator of the Residence in Pediatric Health, Department of Nursing, Health Science Center of UEL. Londrina, PR – Brazil.
[3] Nurse. Adjunct Professor and Vice-Coordinator of the Residence in Pediatric Health, Department of Nursing, Health Science Center of UEL. Londrina, PR – Brazil.

Corresponding Author: Rosângela Aparecida Pimenta Ferrari. E-mail: ropimentaferrari@uel.br
Submitted on: 04/09/2012 Approved on: 09/10/2012

ABSTRACT

This was a qualitative research study aiming to analyze the practice of nurses as well as the advantages and difficulties forin operationng a Program to Support Children´s Growth and Development of the Family Health Unit, in Londrina, Parana. An content analysis was used for data analysis in order to understand the meaning of the unit of the statements of five subjects resulting in the categorization of three subjects: Pediatric health care: conception of family planning for prenatal care; Program of pediatric health care: organization of the work process; Nursing Consultation: detection and disease prevention. The easier aspect for the practic of pediatric health care was the attachment between the team and the woman during the prenatal period and the greater difficulties were in the cultural factors of the mother and family related toregarding adherence to guidelines complicance for children essential pediatric cares.

Keywords: Primary Health Care; Children Care; Community Health Nursing; Family Health Program.

RESUMO

Trata-se de uma pesquisa qualitativa, que teve como objetivo analisar a prática de enfermeiros, bem como as facilidades e dificuldades, para a operacionalização do Programa de Acompanhamento do Desenvolvimento e Crescimento da Criança na Unidade de Saúde da Família, no município de Londrina, Paraná. Para a análise dos dados, utilizou-se a análise de conteúdo, que permitiu apreender a unidade de significação dos discursos de cinco sujeitos, resultando na categorização de três temas: atenção à saúde da criança: concepção do planejamento familiar ao pré-natal; programa de atenção à saúde da criança: organização do processo de trabalho; e consulta de enfermagem: detecção e prevenção de agravos. A maior facilidade para a prática do cuidado da criança é o vínculo entre a equipe e a mulher durante o pré-natal e a maior dificuldade são fatores culturais da mãe e da família quanto à adesão às orientações em cuidados essenciais à criança.

Palavras-chave: *Atenção Primária à Saúde; Cuidado da Criança; Enfermagem em Saúde Comunitária; Saúde da Família.*

RESUMEN

Se trata de una investigación cualitativa para analizar la práctica de enfermeros y las facilidades y dificultades en la ejecución del Programa de Seguimiento del Desarrollo y Crecimiento del niño en la unidad de Salud de la Familia, en Londrina, Paraná. El análisis de datos se realizó según su contenido, lo cual permitió aprehender la unidad de significación de los discursos de cinco sujetos que resultó en la categorización de tres temas: atención de la salud Infantil: concepción de la planificación familiar al prenatal; programa de atención de la salud infantil: organización del proceso de trabajo y consulta de enfermería: detección y prevención de enfermedades. La principal facilidad para la práctica del cuidado del niño es el vínculo entre el equipo y la mujer durante el prenatal y la principal dificultad son los factores culturales de la madre y de la familia con relación a la adhesión a la orientación en cuidados esenciales del niño.

Palabras clave*: Atención Primaria a la Salud; Cuidado del Niño; Enfermería en Salud Comunitaria; Salud de la Familia.*

INTRODUCTION

The well-being of the child through the promotion and restoration of health has been, for a long time, a priority of population health care. In this sense, Brazil has sought to develop strategies in defense of the rights of children and mothers, to combat malnutrition and illiteracy, and the eradication of diseases responsible for deaths of millions of children, every year.[1]

For a healthy growth, basic care is necessary in order to prevent, promote and restore the child's health. Such care should be guaranteed in primary health through practical actions, skills and knowledge, since the Family Health Unit (FHU) is the entrance into the system.[2]

In this context, in order to support the growth and development of children, the Ministry of Health established the lines of care for operationalization of comprehensive care, providing care in the three levels of attention, through preventive actions that encourage autonomy and co-responsibility of the users, as well as, early detection of diseases. The focus of the actions is health, instead of disease, seeking to visualize the child inserted into the family context in every aspect that determines his health and, thereby, reducing morbidity and mortality from preventable causes.[1,2]

Having as a strategic tool the Program of Community Health Agents – PCHA and the Family Health Strategy (FHS), primary health promotes systematic monitoring of children under five years of age and seeks to develop the bond with families, welcoming, co-responsibility and a high degree of problem resolution in services. Furthermore, the planning of actions is directed to the main problems of the population, based on the knowledge of its reality.

There arises, therefore, a rich area of action for the nurse, who plays an important role in the well child visit, through the early detection of health problems and prescription of care, as well as, implementation of intervening actions to improve the quality of care provided to this age group, strengthening the assistance that can reduce morbidity and mortality rates in the region and in the county in which it operates.[3] Such a professional develops his assignments when: he provides consults; guides, trains and defines roles for nursing staff; supervises the activities; performs home visits for high risk children; develops educational actions providing information to mothers; identifies the health status of children related to their conditions of life and their biopsychosocial characteristics.[2,4]

When inserted into a multidisciplinary team, the nurse should organize and coordinate the work processes, as well as acting in an effective manner in providing care to the child. However, this professional has been developing child health actions in an uncordinated way, using truncated guidelines and only dealing with noted complaints, which compromises his vision of the child as a whole. A lack of, effective educational actions and awareness that can guarantee the mother/family health unit attachment is therefore perceived.[5,6] On the other hand, the health service, particularly primary health care, needs to receive professional training related to the domain of the "logical processes of the construction of knowledge and practices coherent with the social, epidemiological, economic aspects", considering the health-disease process of the individual and collective in the different cycles of life.[4:705]

Considering that the attention to pediatric health is a priority area for the nurse's role in disease prevention and health promotion, the present study aimed to analyze the practice of nurses, as well as, the advantages and difficulties for the operation of Program of Community Health Agents in the Family Health Unit.

METHODOLOGY

This was a qualitative study conducted with nurses from the FHU in five regions of Londrina, Paraná, between june and july 2007. The city had 53 basic health units and the study population was composed of five nurse coordinators of the units, who performed pediatric care and management of the unit, having an effective/competitive employment relationship. Therefore, an interview of one nurse in the BHU per region of the city was conducted, that consisted of three of family health (FH) teams, representing the largest regions in population numbers (south, north, east and west). Subjects were selected through a random drawing among the units that had three FH teams and that agreed to participate, after approval by the Committee of Ethics in Research and the Department of Health Care of the Municipal Health Secretary, Opinion No. 061/07, in CAAE No. 0043.0.268.000-07.

To understand the essential aspects of the meanings of the object, individual interviews were conducted and recorded at the BHU, after signing the Terms of Free and Informed Consent. The interview had semi-structured questions, validated by a pre-test, to answer the guiding question: "Tell what health care actions are performed for pediatric health in the Program to Support Children's Growth and Development in this unit."

For data analysis, the recorded interviews were transcribed for comprehension of the relevance of attention to pediatric health in the daily service of the health unit, and to cluster the possible advantages and difficulties. For the analysis of qualitative data, content analysis was used, specifically thematic or categorical analysis, which is rapid and efficient when applied to direct and simple discourse. Thus, the content of the interviews was organized and structured using pre-analysis, exploration of material, and treatment of the results.[7]

RESULTS AND DISCUSSION

The construction of the results was made from the essential aspects of the statements of the nurses regarding pediatric

health care in the *Program to Support Children's Growth and Development* in the basic health unit, which enabled the categorization of three themes: a) pediatric health care: conception of family planning for prenatal care; b) program of pediatric health care: organization of the work process; c) nursing consultation: detection and disease prevention.

Pediatric health care: conception of family planning for prenatal care

In primary health care, the nurse's role in relation to the maternal-child population begins with family planning and continues throughout prenatal care. In the follow statements, it can be observed that the first newborn consultation has also been used by nurses to work with the issue of family planning, contributing to the health care of women and children.

> *[...] Family planning... it is one of the things I try to speak about in this first consultation. I think it's a good opportunity for mothers. She already has a contact with you every month there. I think that family planning is the first thing that I discuss (E2).*

The area of women's health is also one of the priority areas of care in primary care, and currently *The Information System of the Humanization of Prenatal and Birth Program* (SIS-Prenatal) has the intention to improve the access, coverage and quality of prenatal monitoring, giving assistance in delivery, postpartum and neonatal care, subsidizing municipalities and states with important information fundamental for planning, monitoring and evaluation of the developed actions. A study from the 1980s showed that the relationship between policies and maternal-infant programs instituted to lower mortality rates, despite their limits, reflected an improvement in the indicators of neonatal mortality. However, little progress has been made for the effectiveness of public policies that would promote better maternal health care.[8]

In relationship to the strategies that may be used by the nurse to work with family planning, research conducted in the state of Ceará revealed a practice focused on individual counseling with sporadic group activities. Such organization was attributed to the excess of activities with nursing workload, high demand and lack of physicians in some FHS in addition to a lack of support materials and appropriate physical space. Still, 80,0% of surveyed users indicated the nurse as the primary provider of information about contraceptive methods.[9]

Another aspect to be highlighted is that, despite governmental strategies and investments for the promotion of family planning and the performance of reproductive rights, in a conscious and responsible way, teenage pregnancy has reached significant levels and is a public health problem. In this study, the report of nurses showed that this reality was also experienced in the units and represented a difficulty related to the *Program to Support Children's Growth and Development*, in that the teenagers showed little or no maturity and responsibility for the exercise of motherhood .

> *[...] an adolescent gets pregnant and is not ready to be a mother. She became pregnant because she saw a classmate pregnant. The inconsistency, you understand?... There are a lot of girls who become pregnant and do not provide for the child, they have no responsibility. There are so many that we do the family planning, but they don't want to take birth control, they want to be pregnant... 15, 16, 14 years old... Because she saw a pregnant classmate... because otherwise she'll be out of context... have the child. The hard part is to provide for it! (E1).*

Despite the discourse of nurses in this study, it is important that they divest themselves of prejudices regarding teenage mothers, because, in practice, it can be seen that many of them take care of their children in the same way as mothers who are not teenagers, although the Ministry of Health considers this age group one of the determinant of gestational risk for care in the basic health units.[10]

Data from the city of Londrina demonstrated that adolescents – age ranging from 10 to 19 years – were beginning their sexual life, on average, at 14.3 years of age (42.7%). The rate of live births (LB) of adolescent mothers, in the county, dropped from 1.510 in 1998 to 1.040 in 2010, a decrease of approximately 31.0%. In the same period, the state of Paraná presented a drop from 42.244 to 29.045 births, respectively. In Brazil, the rate dropped from 729.816 in 1998, to 552.630 in 2010.[11]

Despite this decrease, these indicators are still considered high. It is necessary and urgent to incorporate systematic instructional activities about sexuality in family planning, aimed at this age group. In addition, health professionals must be prepared to accommodate these clients and provide relevant information to the doubts and anxieties generated in this phase of life.[10]

In relation to prenatal care, the nurse accompanying the pregnant women developed preventive actions aimed at the child's health, guiding the woman in the care for the baby. According to the statements below, it is the monitoring period that facilitated the construction of the link between the professional and the mother, and creates spaces for open dialogue, facilitating adherence to inflexible guidelines and continuity of care after delivery:

> *[...] during the prenatal care the mother is oriented that the person who does the first prenatal care is the nurse. I do the prenatal consultation and talk about the importance of caring for the breast, the cracks... On the*

first day of prenatal care, we talk about the advantages of breastfeeding, the care she needs to do for her body, not having fissures at the breast, we have been working since the prenatal consultations (E1).

[...] as a nurse, I took care of this mother since she got the positive pregnancy test. She starts going through this with me... then, the woman opens herself up, and you create a space with her here, and then the progress of child-care is natural (E5).

In a similar experience in a city of Minas Gerais, in the prenatal program, it showed that pregnant women monitored by a nurse tended to look for her more frequently when she had doubts and problems, more satisfactorily followed the guidelines, and developed more commitment to self-care. In addition to this, the relationship between nurse and pregnant woman enabled an increased confidence, attachment and profissional appreciation.[12]

On the other hand, research conducted in 16 units in the basic health network of the city of Rio Branco-AC showed that, although the great majority of the basic skills expected in prenatal care were developed by nurses, some were performed with low frequency. The results revealed a good performance of the nurses, but the authors concluded that it was appropriate to evaluate the need for clarification of the importance of incorporating care protocols to improve the quality of services in order to achieve better quality pre-natal care.[13]

The Ministry of Health determined there should be a minimum of seven monitoring visits during prenatal care. Studies reported an increase in coverage of prenatal care, as in the higher indicators showed by the SIS-Prenatal process, such as in Quixadá-Ce.[14] On the other hand, even if the women had an adequate number of prenatal visits, problems and unfavorable pregnancy outcomes showed weaknesses in the routine actions of this program related to identification and treatment of diseases subject to detection and prevention.[15]

Therefore, it is important not only to guarantee the realization of prenatal care to the pregnant woman, quantitatively, by increasing the number of consults, but also qualitatively, by investing in team training and instituting clinical protocols, in addition to other measures, as mentioned previously. In the county in question, five protocols were implemented in 2006, including one for women's health and one for pediatric health.[16]

In this study, even though the nurses interviewed affirmed that they initiated guidance to the pregnant woman beginning with prenatal care, none of them referred to the development of educational activities with groups of pregnant women in their units. This activity is recommended by the Ministry of Health in this program, but to realize it, it is necessary to reorganize the work process of the family health teams of the health units.[1,2,8,13]

Program of pediatric health care: organization of the work process

As regards to the monitoring of the growth and development of children, all nurses reported performing it in accordance with the county and ministerial protocol. According to these protocols, it is incumbent on the nurses to make the first visit to the healthy or high risk newborn.[1,16]

In the city, soon after the first visit, in the first month of life, the second consultation is scheduled with the pediatrician. After that, attendance of children without risk is under the responsibility of nursing assistants from each team, in a scheme of "adoption" of the child, until discharge from the program at 18 months of age, when the minimum immunization schedule before completing two years of life is completed.[16] This routine can be inferred in the following statements:

[...] Then, the first well baby visit is done by the nurse, already scheduled, as routine (E1).

[...] Generally I conduct the first well baby visit as soon as he is born, and the rest are up for adoption, for any nursing assistant (E2).

[...] the first well baby visit is with the nurse, then, one is done by the pediatrician and the other monitoring visits are with the nursing assistant (E5).

In cases of high risk children, the continuity of monitoring up to 18 months of age is the responsibility of the nurse. Children are considered high risk, according to the treatment protocol of Londrina, with low birth weight (≤ 2500 grams), prematurity (gestational age ≤ 36 weeks), moderate or severe asphyxia (Apgar score ≤ 7 at 5 minutes), children of adolescent mothers (≤ 18 years), and other criteria identified by the health team.[16]

Although consultations outside of the the risk classification remained under the responsibility of nursing assistants, nurses carried out the supervision of such visits, following the process of team work in pediatrics through spreadsheets, notebooks and notes in the patient records.

[...] I have a folder controlling all the children of my area up to two years, I know who they are... I follow the vaccine schedule... if they are coming back, or not, for well baby visits. I even have those that have been evaluated by particular service... Although I did not continue seeing the children, personally, I always take a look at what they are marking down (E3).

So here we have the notebooks, spreadsheets, we have the names of all the children (E5).

A study about the perception of nurses regarding the articulation of health actions between health team professionals

and the family, verified that they conducted activities of supervision and leadership of the team, supporting in the identification, analysis and resolution of problems in the unit .[17]

Regarding the schedule of consultations, the nurses in this study reported making consultations of children in their coverage area by appointment and in a specific day of the week. This organization was identified as a facilitator in the keeping of appointments, for providing availability of the professional's time, and decrease in the waiting time of the mothers. Likewise, the schedule of care into which nursing assistants were inserted also contributed to the dynamics of service for pediatric care.

> *[...] if she comes with her scheduled time, she is immediately attended. It's the schedule: she already has the day and time scheduled (E1).*
>
> *[...] The staff member who does this well baby visit is inserted into the unit schedule. So, he is programmed for the days that he has the well baby appointment, a quieter time and everything [...] (E5).*

Despite this routine, the nurses do not fail to attend mothers and children arriving at the BHU by spontaneous demand or forwarded from other areas of coverage. On the other hand, the waiting time for mother to fit into the agenda of the nurses is elevated due to other programs to be executed.

> *[...] they are not released, even if they come without being scheduled... So, my greatest difficulty is when they come on their own, not respecting the schedule of the nurses, which is already full [...] (E1).*
>
> *For the nurse it is a rush... there are emergency and other programs. I think we need to have more time, only this... The difficulty is the available time (E4).*
>
> *There are mothers of another area of coverage and that, in the begining, they come to their mother's or mother-in-law's house. In such cases, as the mothers or the mothers-in-law are in our area of coverage, the CHA is called, and we likewise do the visit. Then, depending on the mother, we call the other unit scheduling for the pediatrician, to make everything right (E5).*

Regarding the place of consultations, the nurses, E2 and E4, referred to performing these at homes, churches and shacks, in order to be closer to the community for understanding the socioeconomic and environmental conditions of the family. On the other hand, E1 stated he did not do it in the home, because he sees it as a paternalistic practice.

> *[...] I know it has a unit that goes in the house, now, I do not like... I think you're being paternalistic there (E1).*
>
> *[...] In my area of coverage the consultations are here in the station and also in microareas, we use churches, shacks, whatever is closest; as close to the community as we can find, it's better (E2).*
>
> *[...] Generally, when the baby is born, we do the consultations at home, in order to check the conditions in which the child is living there. Hygiene, socioeconomic family conditions (E4).*

The consultation conducted in community settings closer to families can be considered as a creative practice used by teams to facilitate user access to services, demonstrating a paradigm shift that permeates the actions of professionals.

In relation to the first call, in which mother and child must be met at the BHU, the deadline for its implementation proposed by the Ministry of Health is the first week after birth, which is a most vulnerable period in which the highest rates of infant death are concentrated.[1] The concern of nurses can be observed in the following words, to perform the consultation, according to the protocol and organization of the work of the teams. Such an arrangement favors the initial consultation, within the period established by the Ministry of Health.

> *[...] as the CHA has already had a notion of all pregnant women, then, they are eyeing when a baby is born, to call them in the first week. As soon as they leave the hospital, in the first week they are called (E2).*
>
> *[...] we have a control of all pregnant women, of the expected delivery date. We have the CHA, who are making visits to these women. Then, I try to point them to keep an eye out, especially when it is to be born, to be able to make the first assessment in seven days (E3).*

The organization of the work process in the units facilitates the development of public health surveillance, providing comprehensive care and reducing infant mortality in the city. This is evidenced by the reduction in the infant mortality rate of Londrina in recent years. There was a decline from 14.3/1.000 live births in 2000 to 10.5/1.000 live births in 2009.[18] This decline can be attributed to the expansion and improvement of basic health care in the county, although 77.1% were considered reducible among the neonatal deaths by adequate control of pregnancy and childbirth, and 17.5% avoidable through partnerships between health sectors.[19]

Another active surveillance strategy is to seek absentee children, through community health agents (CHA), through home visits and delivery of communications provided from the nurse. Furthermore, in some cases, there was even the intervention of the Guardianship Council with mothers, to ensure the basic responsibility for the care of the child.

If they do not come, I reschedule, sending them a note through the CHA, calling... I make three calls. If they do not come, then we make a home visit... if we don't see them, I call the the Guardianship Council (E3)

> *[...] the CHA goes there, the nursing assistant goes and everything... Showing that it is an obligation to bring the children. It is the child's right. [...] These are the mothers that we always have to be watching... So, the majority we get in this way. When you cannot, maybe the Guardianship Council has to get in the middle (E5).*

The monitoring done by the team of primary care is addressed to persons with more vulnerability, and systematic monitoring in risky situations aims to reduce health disorders, executing strategies such as: home visits to capture users and active search of those who evade the programmed monitoring. Thus, in the home visit conducted by the CHA in the last month of pregnancy and the first week of life of the child is a priority action of maternal-child vigilance.

In this way, one can realize the importance of the performance of the CHA, so that there is a dynamic flow of care and health surveillance, because they constitute a link between the service and the community, facilitating the performance of the activities of nurses in the team.

> *[...] having the FHP and the CHA that are our link to the community. Without them we would not be monitoring with so much discretion, doing the well baby visits [...] (E3).*
>
> *[...] I think the family health was very good because it has a much greater connection with the community. I think that it is this bond that you create with the community (E5).*

A study also showed that nurses valued the work done by the CHA, because they had important information that supported their work and that of the other team members.[17] Both the PACS, such as the FHS, emerged in order to restructure the municipal health systems, replacing the model of care based on the enhancement of the hospital and the disease model, focused on promoting the health of the families, community participation, and the role of multidisciplinary teams to replace the physician-centered work. Such characteristics break with the passivity of basic health units, stimulating intersectorial practice.

However the proposal for a structured work from multidisciplinary teams does not guarantee a break with the medical-centered dynamics, because some of the difficulties of the FHS were related to the configuration of the process work, which must be reorganized as part of the new technologies of work. Therefore, it is necessary that the worker develop relational skills that favor welcoming and user interaction, stimulating autonomy in health care, as well as co-responsibility. [20]

In this regard, it is clear in the statements of the nurses who, in the search for the organization of the process of work looked toward the welcoming, bond formation, listening and dialogue, the incentive for co-responsibility and autonomy of the user, as an active subject in the promotion of her health, also facilitates the development of the program in the unit.

> *I think the function of the FHP is to educate and to make the transformation of habits... it must give commitment to the mother... because I am here, in an environment in which, if you start to give... they become without responsibility [...] They transfer all responsibility for you. That's not cool. They must have responsibility. [...] Even with the dog there had to be fellowship, with the parrot, the parakeet, with the birds... Then you develop a bond between professional and family [...] (E1).*
>
> *[...] to say, also that you do not need to bring everything to the unit, because some things you can do at home (E4).*
>
> *[...] But we have cases in which this co-responsibility does not happen and it seems that there is only the responsibility of the unit (E5).*

It is necessary to instruct the population for the understanding that the health system requires joint action by all social actors, strengthening the autonomy of individuals in health care and the option for a healthy lifestyle.[20]

Nursing consultation: detection and disease prevention

As noted earlier, the pediatric nursing consultation happens in the first days of life, and it is of fundamental importance. It allows nurses to perform early diagnosis and more effective guidance on breastfeeding, since this is a time when the mother opens up and talks about her anxieties in regard to the baby and the family, enabling therapeutic communication, as shown in the following statements.

> *[...] Here you establish a bond, you are a therapist, you are all there is... because it is not only the act of the procedure itself, you lend your ears... you lend your ears (E1).*
>
> *[...] When I lose the child's attention a little and I will look at the mother. 'And you? How are you? How are you feeling caring for the child?' (E2).*
>
> *[...] Then, suddenly, you get a child that you measured the head circumference in the beginning of his life, and from there in one month it has not evolved. It's fast, you*

pass them to the pediatrician, if not you discuss with the pediatrician and already in that day there is a referral to a neurologist [...] (E5).

Nursing consultation is a private nursing action, contemplated in the Exercise of Professional Practice Law n. 7.498/86. It is an activity that allows the professional to address customer service, moving away a bit from bureaucratic functions that pervade daily activities. Furthermore, it guarantees autonomy in the exercise of professional nursing interventions and on the problems detected and interaction between the provider and the client in the pursuit of health promotion and disease prevention. For this, the nurse is required to look and use clinical reasoning to help guide the actions and improve the outcomes of care provided.[21,22] It is noted in the statements that this competence has been developed by nurses, contributing to the dynamics of the service.

[...] You just have to take a look, to see that the child has some problem, he is very skinny, very underweight, then you have to be even more on top of it (E4).

[...] Sometimes, the mother is accustomed to that little way of that child; we took two months to see, and when you take a look, you see "hum... he is very bright white, mother, is he not?" "Oh, I did not notice anything." Then you put the hand of the mother with the child's hand and already that gives a little look... sometimes in a month you have noticed some change (E5).

One of the necessary conditions for the successful implementation and maintenance of the nursing consultation is the technical preparation and development of guides of conduct.[22] This is a reality experienced by nurses, who rely on the municipal protocol, as previously mentioned. This becomes a facilitator, ensuring more autonomy in their actions.

[...] Because here we have a care protocol and, if everything is running well with the child, we follow the protocol... we have a care protocol that gives security to us to make certain actions and behaviors (E3).

However, although treatment protocols facilitated the work dynamics and assured support to the actions of the nurse, we cannot make the mistake of depending on a manual, losing creativity in finding solutions, different from the conventional. Regarding the nursing consultation, the following reports demonstrated the main actions that addressed prevention and health promotion and the early detection of health problems.

[...] I do well baby visits and the postpartum consults, both of the mother and the child, Childcare visits linked with postpartum... you go to do the visit... all of those guidelines: the advantage of breastfeeding, care, preventive measures of accidents... the paperwork you must also complete... the paperwork is large... at that time you will guide everything: nutrition, hygiene, it is... dengue, you have to guide everything and everybody! (E1).

[...] already made the postpartum consult of the mother and newborn. Mostly all the orientations of breastfeeding... my biggest focus is breastfeeding, skin coloration, hygiene guidelines, accident prevention, everything (E3).

[...] The issue of iron deficiency... errors in feeding... most times you have a child with malnutrition. But we also have cases of obesity, too... I try to provide the guiding orientation of preventing disease and, for example, dermatitis, which is common at this stage... (E4).

Such actions include those recommended by the Ministry of Health, aimed at reducing infant mortality, by means of monitoring the child for growth and development, immunization, breastfeeding promotion and healthy eating, attention to nutritional disorders and deficiency anemias, as well as an approach to the respiratory and infectious diseases.[1]

Actions to promote breastfeeding are a priority in monitoring the child, because according to the Ministry of Health, exclusive breastfeeding until six months and complemented with appropriate foods up to two years of age or older have a positive impact on growth and development, preventing diseases in childhood and adulthood.[1] Thus, there is an evident concern to strengthen guidelines referring to breastfeeding, this being an action initiated in the prenatal period, according to the previous explanation.

The greater difficulty in performing the nursing consultation, detected in the following discourses, is the strong influence of culture, family beliefs and myths that, many times, prevented adherence to the guidelines of the professionals of the service.

[...] There are myths, beliefs... you have a mother that you say "you do not need to put money in the belly button", but no, she does... And there are those who say, 'My grandmother did that to her son, she has always done what is right and now I am not going to change that (E2).

[...] Now, what makes it difficult is the resistance of some mothers... such culture... sometimes you want to do something and you cannot [...] (E3).

Although the education related to health involves a change of attitude and paradigms of the population, transforming aspects ingrained in the culture of individuals is a difficult task and requires the development of a bond, trust and respect on the part of the professionals. Knowing the values, habits and beliefs,

respecting the meaning of these for the families, is the first step in order to develop an open dialogue and a productive and transformative relationship between the professional and the user.[20-22]

Under this aspect, the nursing consultation can also be performed during the home visit, understanding the context in which the child lives. This strategy was an important tool used by the FHS nurses in this study, as mentioned earlier. It enabled the professional to know the real conditions of the life and health of the families, the concepts they had about the disease process, the habits and strategies they used to prevent and treat diseases.

A home visit, for it to be productive, should be planned and based on objectives outlined previously. Its implementation requires specific professional skills in the use of interview techniques and systematic observation, through development of the principles of participation and shared responsibility, respecting the beliefs, values and sociocultural differences. From such contact, the bond between the professional and the mother is strengthened.[1,21]

The information collected in the home favored the planning of actions undertaken by the nurse and team, and made it possible to adapt the guidelines to the reality of the family and to work with the differences and particularities of each one, still encountering difficulties in the work with differences and in tailoring guidance to the reality of families. This is because the socioeconomic conditions of the population are precarious and the resources for health care and basic needs are scarce, as shown in the following statements:

> *We say: "the money you will spend buying milk, buys you milk for the whole family... NAN is expensive, with fifteen real (R$15) given to buy a basic food basket... feeding the entire family[...] "(E1).*
>
> *[...] It is very difficult to make a guideline of nutrition, hygiene, care when the mother lives in a shack, barely has rice and beans, and you are teaching carrots, potatoes... The time that you are faced with the reality, as we call "the area down there"... it is even my greatest difficulty (E2).*
>
> *[...] So we try to go to the house to see the socioeconomic condition of the family and be able to make a proper guidance, especially, nutrition and hygiene... this guidance is in vain if you are not accompany them in the field (E4).*

We know that health is the product resulting from the guarantee of adequate working conditions, nutrition, housing, sanitation, education and environment. And despite the socioeconomic, cultural and political processes presenting significant changes as a result of capitalism and globalization, the result is the increased vulnerability of the population, especially in underdeveloped countries.[23]

These conditions lead the population to continually seek the services of health care and to procure solutions for their problems. Therefore, it becomes necessary that professionals understand the multiple factors that interfere in the process of health and illness and their function as agents of change in society, procuring alternative solutions within the scope of their governance.[20,23]

In this perspective, it is also necessary to develop and implement healthy public policies in all sectors of society, recognizing their complexity and intersectionality and the influence they exercise on health, creating environments which favor legally established aspects, such as work, leisure, home and school.

FINALCONSIDERATIONS

The statements presented by the nurses showed the daily search for strategies that promoted welcoming, strengthened the bond between the population and the professional, and stimulated co-responsibility of the actors involved in pediatric care. Such efforts to perform the competencies expected of workers in the network of primary health care were faced with the difficulties experienced by them in the development of resources in the face of barriers of the health system itself, as well as cultural values and socioeconomic aspects of the mother and her family context.

Finally, the pediatric health care practices performed by nurses, despite appearing to be guided by preventive and health promotional actions, in conformity with the ministerial and municipal protocols, still showed fragility in compliance with all programmatic actions. This fact reflects the possible ineffectiveness of the quality of care and refers to the need to understand how such a practice is exercised and what are the difficulties faced in the implementation of comprehensive care. Therefore, further research should be conducted to investigate the effectiveness and impact of actions developed for the child in the service of primary health care, for the healthy growth and development of this age group.

REFERENCES

1. Brasil. Ministério da Saúde. Departamento de Atenção Básica de Saúde. Agenda de Compromissos para a Saúde Integral da Criança e Redução da Mortalidade Infantil. Brasília: MS; 2004.
2. Del Ciampo LA, Ricco RG, Daneluzzi JC, Del Ciampo IRL, Ferraz IS, Almeida CAN. O Programa de Saúde da Família e a Puericultura. Ciênc Saúde Coletiva. 2006; 11(3):739-43.
3. Abe R, Ferrari RAP. Puericultura: problemas materno-infantis detectados pelos Enfermeiros numa Unidade de Saúde da Família. REME - Rev Min Enferm. 2008; 2(4):523-30.
4. Sousa FGM, Erdmann AL, Mochel EG. Modelando a integralidade do cuidado à criança na Atenção Básica de Saúde. Rev Gaúcha Enferm. 2010; 31(4):701-7.
5. Figueiredo GLA, Mello DF. A prática da enfermagem na atenção à saúde da criança em unidade básica de saúde. Rev Latinoam Enferm. 2003; 11(4):544-51.

6. Leite MS, Andrade ASA, Lima MLD. AIDPI: conhecimento dos enfermeiros da atenção básica do município de Aracaju-SE. REME - Rev Min Enferm. 2011; 15(4):481-90.
7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2009.
8. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Saúde de mães e crianças no Brasil: progressos e desafios. Lancet. 2011; 377:1863-76.
9. Moura ERF, Silva RM. Informação e planejamento familiar como medidas de promoção da saúde. Ciênc Saúde Coletiva. 2004; 9(4):1023-32.
10. Brasil. Ministério da Saúde. Secretaria de Atenção a Saúde. Departamento de Ações Programáticas Estratégicas. Gestação de alto risco: manual técnico. Brasília: Ministério da Saúde; 2010. 302 p.
11. Datasus. Departamento de Informática do SUS. Informações em Saúde. Nascimentos e Mortalidade de 1996 a 2009, pela CID-10, Paraná e Brasil. [Cited 2011 Dec 2011]. Available from: http://www2.datasus.gov.br/DATASUS/index.php?area=0205&VObj=http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sim/cnv/inf10.
12. Mello DF, Andrade RD. Atuação do enfermeiro junto à população materno-infantil em uma unidade de saúde da família no município de Passos-MG. REME Rev Min Enferm. 2006; 10(1):88-93.
13. Cunha MA, Mamede MV, Dotto LMG, Mamede FV. Assistência pré-natal: competências essenciais desempenhadas por enfermeiros. Esc Anna Nery Rev Enferm. 2009; 13(1):145-53.
14. Grangeiro GR, Diógenes MAR, Moura ERF. Atenção Pré-Natal no Município de Quixadá-CE segundo indicadores de processo do SISPRENATAL. Rev Esc Enferm USP. 2008; 42(1):105-11.
15. Figueiredo PP, Lunardi Filho WD, Pimpão FD. Mortalidade infantil e pré-natal: contribuições da clínica à luz de Canguilhem e Foucault. Rev Latinoam Enferm. 2012; 20(1):201-10.
16. Londrina. Autarquia Municipal de Saúde de Londrina. Saúde da criança: protocolo. 2006. [Cited 2011 Dec 20]. Available from: http://saude.londrina.pr.gov.br/protocolo_saude/.
17. Calomé ICS, Lima MAD, Davis R. Visão de enfermeiros sobre as articulações das ações de saúde entre profissionais de equipes de Saúde da Família. Rev Esc Enferm USP. 2008; 42(2):256-61.
18. Datasus. Departamento de Informática do SUS. Informações em Saúde. Nascimentos e Mortalidade de 1996 a 2009, pela CID-10, Paraná e Brasil. [Cited 2011 Dec 20]. Available from: http://www2.datasus.gov.br/DATASUS/index.php?area=0205&VObj=http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sim/cnv/inf10.
19. Ferrari RAP. Mortalidade Neonatal no Município de Londrina-Paraná: características maternas, dos recém-nascidos e uso do sistema de saúde, de 2000 a 2009 [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2012.
20. Pinheiro R. Integralidade em saúde. Ciênc Saúde Coletiva. 2007; 255-62. [Cited 2011 Dec. 20]. Available from: http://www.epsjv.fiocruz.br/upload/d/integralidade.pdf.
21. Machado MMT, Leitão GCM, Holanda FUX. O conceito de ação comunicativa: uma contribuição para a consulta de enfermagem. Rev Latinoam Enferm. 2005; 13(5):723-8.
22. Rios CTF, Vieira NFC. Ações educativas no pré-natal: reflexão sobre a consulta de enfermagem como um espaço para educação em saúde. Ciênc Saúde Coletiva. 2007; 12(2):477-86.
23. Sena RR, Silva KL. Políticas e práticas de saúde rumo à equidade. Rev Esc Enferm USP. 2007; 41(Esp):771-6.