



Limit-situations in child health care practices: challenges to the empowerment of nurses*

Situações-limite às práticas de promoção da saúde da criança: desafios ao empoderamento dos enfermeiros

Situaciones límite para las prácticas de promoción de la salud infantil: retos para el empoderamiento de los enfermeros

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ABSTRACT

Objective: To analyze the limit-situations experienced by nurses in child health care practices, from the perspective of empowerment in health promotion. **Method:** This is a qualitative approach Participatory Action Research, supported by Paulo Freire's Research Itinerary, developed through Culture Circles, consisting of three stages: thematic investigation, coding and decoding and critical unveiling. 13 Culture Circles were held with nurses from the Family Health Strategy of five Basic Health Units in the city of Manaus, Amazonas. **Results:** A total of 16 nurses participated and 20 generating themes emerged from the Culture Circles, six of which were considered limit-situations by the participants: accumulation of activities; difficulty monitoring and following-up children; work focused on productivity; lack of training; limited human resources; difficulty in reception. **Conclusion:** The study contributed to strengthening nurses through reflective dialogues on the realities experienced, increasing awareness and enabling interventions to transform their practices in child health care.

DESCRIPTORS

Empowerment for Health; Child Health; Pediatric Nursing; Primary Care Nursing; Health Promotion.

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INTRODUCTION

Child health care, especially in early childhood (the first six years of age) has been a priority in government agendas worldwide. The Declaration of Alma-Ata, elaborated at the First International Conference on Primary Health Care (1978) discussed maternal and child health care in all countries, as well as other problems such as proper nutrition, basic sanitation and immunization against the major infectious diseases⁽¹⁻³⁾.

In Brazil, after the creation of the Child and Adolescent Statute (1990), children received attention focused on the conditions of development and citizenship. In 2011, the so called “*Red Hemisférica de Parlamentarios y Ex Parlamentarios por La Primera Infancia*” gave rise to several initiatives such as the social programs *Programa Brasil Carinhoso* (2012), *Bolsa Família* and incentives to expand early childhood education. Recently, the Legal Framework for Early Childhood (2016) established principles and guidelines to ensure the development of effective public policies for early childhood⁽³⁾.

In this perspective, with the objective of guiding actions and services in the child health care network, the National Policy for Comprehensive Child Health Care (PNAISC – *Política Nacional de Atenção Integral à Saúde da Criança*) was created in 2015, with its last implementation in 2018. The PNAISC contains principles, guidelines and strategic lines of action, with the objective of “promoting and protecting child health and breastfeeding, through comprehensive and integrated care from pregnancy to nine years of age, with special attention to early childhood and to the most vulnerable populations⁽⁴⁾”.

These initiatives have contributed to the improvement of several indicators, such as coverage of Primary Health Care (PHC), access to vaccination and to prenatal consultations, breastfeeding incentive, better maternal education, reduction of poverty and reduction of hospitalizations for conditions that can be treated in primary care. The child mortality rate of children under five in the country decreased by more than half, dropping from 90 to 43 deaths per 1000 live births between the years 1990 and 2015⁽⁵⁻⁶⁾.

On the other hand, infectious agents and diseases that were considered under control have been reappearing. High rates of cesarean delivery, prematurity, childhood obesity and deaths due to preventable causes, accidents and violence are identified by public policies as major challenges to be overcome to achieve full growth and development of children⁽⁷⁻⁸⁾.

In this context, as a way to overcome the problems in child health care, it is important to discuss the contemporary concept of Health Promotion (HP), defined in the Ottawa Charter (1986) as the “process of enabling a community to act towards the improvement of their quality of life and health, including greater participation and control over this process”. In this sense, this concept goes beyond health institution to include social, environmental, and cultural dimensions, with a view to strengthening the individual, the family, and the community. In addition, training and participation of the population as active subjects in their social determinants of health is encouraged⁽⁹⁻¹⁰⁾.

Among the HP action fields, reorienting health services and developing personal skills as support for participation in child health promotion stand out. The Ottawa Charter emphasizes that the responsibility for HP must be shared by different sectors, including health professionals and especially nurses⁽⁹⁾.

Professional nurses in primary care, more precisely in the Family Health Strategy (FHS), develop their work in child health through a set of actions of childcare, an area of pediatrics that consists of comprehensive care for child protection, disease prevention and health promotion. This work can be developed in the health unit, in households and in different community spaces, such as schools, associations, churches, community groups, among others. Family contexts and social and health determinants must be taken into consideration⁽¹¹⁾.

Studies indicate that nursing practices in child health care are based on a curative approach, centered on the disease and carried out in an individualized and fragmented manner. This is associated with lack of training, work overload and excessive administrative activities. These difficulties and challenges are related to the limit-situations experienced by these professionals⁽¹¹⁻¹²⁾.

Thus, it is important to enhance nurses’ personal skills and practices in child health care, seeking to consolidate the health promotion policies in primary care. For that, the term empowerment is used as one of the main elements for achieving health promotion. In HP, empowerment is defined as a process that coordinates individual and collective strengths and competences to obtain proactive behavior, resulting in social transformation. In this sense, it allows the professional to have greater control over their practice and acquire a critical and reflective perspective of their surroundings^(9,13-14).

It should be noted that the word empowerment is polysemic in literature, as it is used with different connotations and meanings. However, in this study, empowerment is discussed from a critical-social perspective, described by some authors as a transformative and emancipatory approach, which privileges power-with and not power-over the other⁽¹³⁻¹⁵⁾.

It is believed that strengthening nurses can help them face challenges (limit-situations) for the promotion of child health and, consequently, improve the quality of life of families and the development of children. Therefore, this study is based on the following guiding question: what are the limit-situations experienced by nurses in the development of their work in child health care?

Thus, the present study aimed to analyze the limit-situations experienced by nurses in child health care, within the perspective of empowerment in health promotion.

METHOD

STUDY TYPE

This is a participatory action research with qualitative approach. The methodological framework used as

support was Paulo Freire's Research Itinerary, carried out through Culture Circles consisting of three interdependent stages: Thematic Research, Coding and Decoding and Critical Unveiling⁽¹⁶⁻¹⁸⁾. The "Culture Circle" conceived by Paulo Freire is a dynamic space in which a dialogic relationship between the participants is established, starting from discussions and reflections about the realities experienced, which, when unveiled, reveal possibilities of intervention⁽¹⁶⁻¹⁸⁾.

The thematic research stage is conducted by gathering the generating themes (which subjects brought up for discussion) that emerged during the dialogic meetings with the study participants. In coding and decoding, the participants look for the meanings and understandings of these generating themes and perceive them as limit-situations or problems to be dealt with. Thus, the participants acquire a critical-reflective view, which culminates in an action-reflection-action process, in which a range of possibilities to deal with the limit-situations is learned, thus completing the last stage of the Culture Circle, critical unveiling.

SCENARIO

The study was carried out in the city of Manaus, Amazonas state, located in the North Region of Brazil. The city's Health Care Network (HCN) is organized by Health Districts (HDs), divided into HD North, HD South, HD East, HD West and HD Rural. The HCN of Manaus has Primary Care Center (PCC) where Primary Care teams (PCt) and Family Health teams (FHt) operate. Some PCC work only with PCts, others with PCts and FHt, and 12 of these units operate with three to five FHts⁽¹⁹⁾.

SELECTION CRITERIA

The PCCs included in the study were those that had between three and five FHts in them and that had nurses in their teams during the research period. The choice to include only the PCCs that had three to five FHts was because the teams are in the same physical space, which allowed grouping the nurses and holding the Culture Circles. Therefore, of the 12 PCCs with three to five FHts implanted, five were part of the research: one in HD North, two in HD East and two in HD West. The PCCs of HD Rural were not part of the study because they have specific dynamics in their work process to serve the riverine communities.

DEFINITION OF THE SAMPLE

The study included 16 nurses who worked in PCCs with three to five FHts and who had worked for at least one year in the FHS. Two nurses were excluded because they were on sick leave at the time of the meetings and two professionals refused to participate in the research.

DATA COLLECTION

The research was divided in three moments: the first occurred by approaching the field through visits to HDs and dialogue with managers, with the objective of identifying the FHts and clarifying the objective

and method of the study; the second occurred through meetings that were held with the participants to clarify the study and establish a bond; the third moment was the completion of the stages of the Cultural Circles of Paulo Freire's Itinerary.

Data collection was carried out by the researcher with the collaboration of a research assistant who was trained to assist in the mediation of the Culture Circles (meetings) with the participants. Usually, the Culture Circles (meetings) were held in the meeting spaces of the PCCs and occurred every 15 days during the collection period, as previously agreed upon according to the availability of the participants. Three meetings were held in each PCC, with the exception of PCC Resolution, where there was only one Culture Circle due to the unavailability of the participants. There was a total of 13 Culture Circles, with the participation of three to five nurses per meeting and a duration of one and a half to three hours each meeting.

The meetings were always conducted with the participants organized in a circle, so that everyone could look at each other, enabling a collective, interactive, and participative dialogue, as proposed by the Paulo Freire's Itinerary.

DATA ANALYSIS AND TREATMENT

According to Freire's Itinerary, as collection and analysis are interdependent stages, they are done simultaneously. The following guiding questions were asked to guide the discussions in the first stage: where and when do child health care actions occur and who develops them? What do you understand about the concept of health promotion? What are the limits, difficulties and potentials found in the development of children health care practices? What do you understand about the concept of empowerment?

After the meetings of the first stage, the research material was fully transcribed using an audio recorder and a field diary. In the second stage, the 20 generating themes raised by the participants were re-presented to them with the help of a notebook and a projector; at the same time, the participants recognized the themes using cards, brown paper and colored pens, in the coding and decoding stage. After each meeting in the second stage, the material was transcribed and presented to the participants again for discussions and reflections regarding the understanding and meaning of the generating themes. In the third stage, the themes, coded and decoded by the participants, were unveiled through an action-reflection-action process. Thus, participants became aware of the limit-situations experienced by nurses in their practices in child health care.

ETHICAL ASPECTS

The study was initiated only after obtaining approval from the Research Ethics Committee of the Universidade do Estado do Amazonas (UEA), under protocol number 2.110.911/2017, considering the ethical criteria and the recommendations of Resolution no. 466/2012, from the National Health Council. The investigation occurred between July 2017 and February 2018. After accepting to

participate in the study, the professionals signed the Informed Consent Form (ICF). To guarantee the anonymity of the participants, their names were replaced by terms of Paulo Freire's "Pedagogy of the oppressed". As for the PCCs, they were identified with the names of the principles and guidelines of PHC: Universality, Equity, Comprehensiveness, Territorialization and Resolution^(17,20).

RESULTS

Out of the 16 nurses participating in the study most were female (75%; n=12), the mean age was 38.5 years (ranging from 31 to 48 years) and the time of work in the FHS varied from one to 15 years. It is worth noting that 7 nurses (43.8%; n=7) reported having a specialization in Family Health and 8 (56.3%; n = 8) did not have a graduate degree.

The 20 generating themes that appeared in the first stage of the Itinerary were reduced in the second stage to six themes that were identified by the participants as limit-situations: 1. Accumulation of nurses' activities; 2. Difficulty monitoring and following up children; 3. Work focused on productivity; 4. Lack of training for nurses; 5. Limited human resources; 6. Difficulty in Reception.

The themes 1. Accumulation of nurses' activities and 2. Difficulty monitoring and following up children emerged from discussions and reflections on the guiding questions on practices developed in child health care and understanding of the concept of HP.

It was found that child health care practices are developed by both nurses and doctors, through childcare consultations. Each of these professionals does consultations independently. The participants revealed strategies for the follow-up of the children: scheduling the subsequent consultation after the first postpartum visit at home; combination of the consultation schedule with the vaccination calendar; and linking childcare nursing consultations to the social programs "Leite do meu Filho" and "Bolsa Familia".

In the discussion on the concept of health promotion, nurses expressed difficulties in understanding and made no distinction between disease prevention and health promotion:

Health promotion is everything aimed at the individual's physical, psychological and social well-being. Here we work a lot with this, prevention and treatment of communicable or contagious diseases (Love).

I think that disease prevention is a form of prevention, basic guidelines on the vaccination schedule, nutrition, breastfeeding, that is, the main things for the child's growth and development (Conscience).

Nurses coded and decoded theme 1. Accumulation of activities reporting several situations that they experienced and which they considered limit-situations. They revealed that they assume responsibility for most of the programs in Primary Care actions, and also take on administrative and bureaucratic tasks, conflict management in the health team and other community activities (home visits and actions

in the Health at School Program). They also reported in this theme the high turnover of doctors in the FHS, which hinders team bonding and work in the FHS:

A lot of times the problem is not an exclusive competence of the nurse, it is the responsibility of the unit; we end up solving all the problems because doctors do not get involved (Conscience).

The nurse has to do everything, even managing human resources and coordinating all the activities of the unit, which are not their function. (Emancipation).

The nurse is responsible for everything, the doctor in the Program "More Physicians" spends little time in the unit and does not create a bond with the community (Dialogue).

Nursing practices in child health care were discussed considering the work process. The dialogue on the theme 2. Difficulty monitoring and following up children showed their difficulty in carrying out an active search for children/families, problematizing them as limit-situations, such as the lack of security in the community and the inclusion of up to five FHts in a single PCC.

An important factor for follow-up is when mothers return from the puerperium and bring their children. But, as we work through free demand and the PCC opens its doors to other neighborhoods outside the coverage area, these children go to the first appointment and then do not return to follow-up due to the distance (Reflection).

Limited human resources was another theme revealed by the participants. They emphasized that the FHts do not have enough Community Health Agents (CHA) to assist the micro areas of the territory covered. In addition, many CHAs were deviated from their role, taking on demands from PCC and not from FHt, and a good part of them already had a technical nursing course.

The nurses also pointed out the low adherence of mothers to the continuity of the children's monitoring at the PCC, since they sought the unit only in case of illness:

Adherence to treatment is better than to follow-up, because mothers bring children to the unit when they have the flu or a ringworm, only problems that they cannot solve at home (Transformation).

The themes 3: Work focused on productivity, 4: Lack of training and 6: Difficulty in reception emerged from the discussion on the limits, difficulties and potentials found in the development of child health care practices and on the understanding of the concept of empowerment.

The generating theme "work focused on productivity" was surrounded by limit-situations represented by the stipulation of health indicator goals, for which the district management did not consider the local diagnosis of each FHt. In the discussions among nurses, they expressed the difficulty of meeting the demand of 12 consultations per shift, determined by the health districts:

In the past it was very good to work in FHS, today the philosophy has changed, now the priority is to reach a goal... (...) and

the community does not welcome you anymore, there is a lot of violence (Oppressed).

Health promotion is not feasible (...) our schedules are very full, there is no space for these actions (...) the priority is the quantity and not the quality of the service (Reality).

Nurses showed they were not prepared to care for children and their families, due to the limited availability of in-service training directed to this population. They expressed the need to develop manuals and protocols to guide the care of children/family members.

In the dialogues regarding the generating theme 5. Limited human resources, as a consensus between all participants, this theme was reduced to theme 2. Difficulty monitoring and accompanying children. The generating theme 6. Difficulty in reception was pointed out as a problem due to the lack of preparation of the team to perform reception, which was restricted to the mere screening of patients at the reception of the PCC. The discussions showed that the presence of sufficient and adequate infrastructure and equipment for the development of actions was perceived as a potential by nurses.

As for the concept of empowerment, when proposed to the participants as a guiding question, some even expressed their ideas of concepts, but the theme remained veiled among nurses. Thus, to stimulate the debate, participants were asked to provide examples of situations experienced.

Empowerment of mothers in prenatal care is to involve the father in consultations, we take the opportunity when doing the rapid test and already give prenatal guidelines, request exams from the father and do a nursing consultation, then so many of them adhere to the prenatal care (Action).

In the last stage (critical unveiling), the participants, guided by the reality of their practices in child health care reflected in the work process, recognized the need for reflection on the concept of health promotion. The Culture Circles unveiled the need to coordinate their activities with the team, in order to share the work demands at the PCC, and the importance of considering users as active subjects in the health and disease process, to improve adherence to children's follow-up. Figure 1 illustrates the process of the three stages of the Culture Circle.

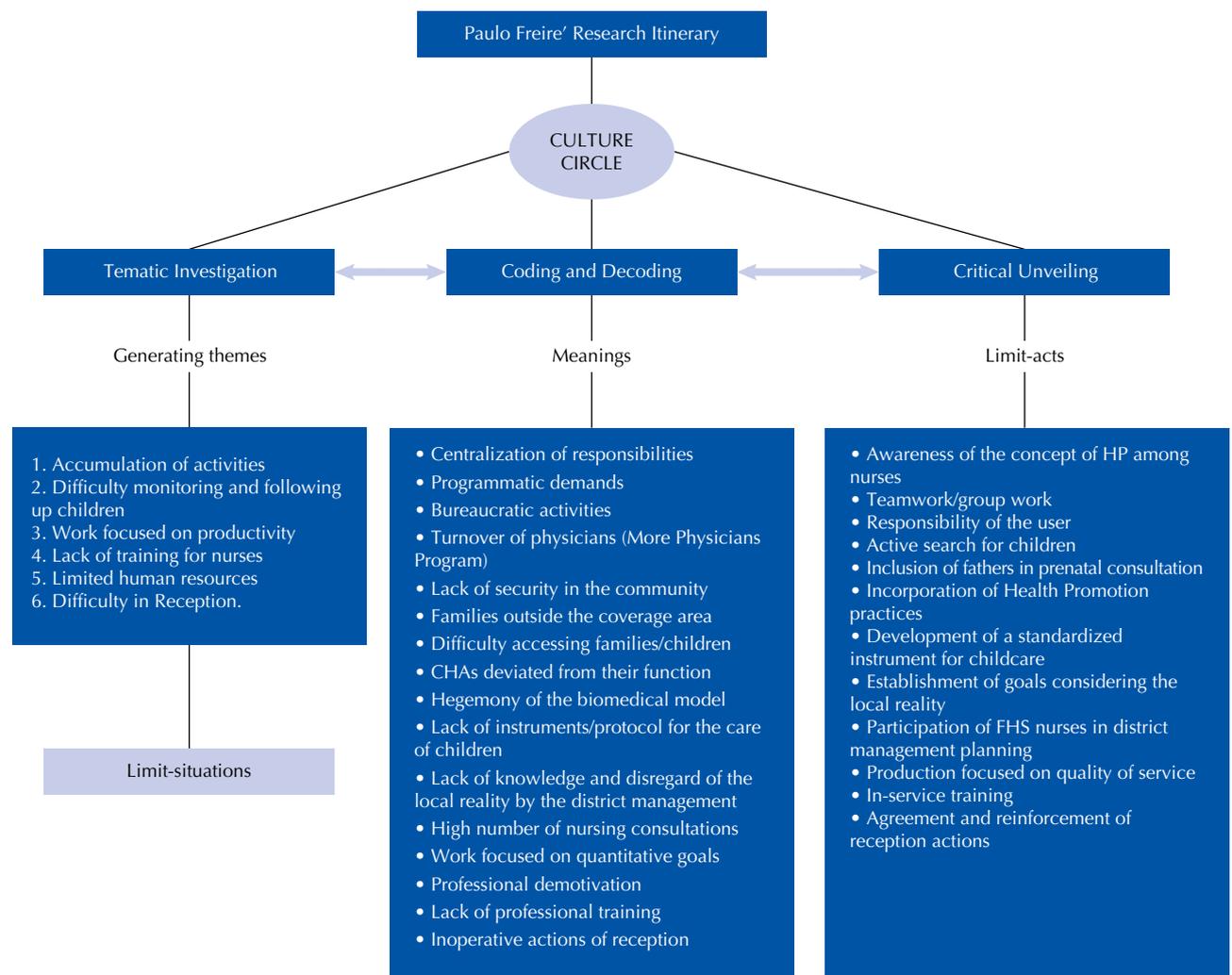


Figure 1 – Paulo Freire's Research Itinerary Diagram.

The participants referred to the need to be in closer contact with the professionals responsible for the technical area of local child health in order to recognize the reality of the workplace of nurses from the FHT, as well as the preparation for reception actions in the PCCs, which, in some units, were not agreed upon and conducted.

DISCUSSION

As the Culture Circles occurred, nurses became aware of the limit-situations experienced in their daily practices in child health care. When reflecting on the concept of health promotion described in the Ottawa Charter, the participants realized the importance of incorporating health promotion into their practices. During the meetings, reflections on the work process were shared, pointing out problems such as the accumulation of activities and centralization of responsibilities, demanded by activities that were more focused on bureaucratic, administrative and assistance issues than on community actions, home visits and health education.

Studies indicate that nurses' actions are largely concentrated in administrative and bureaucratic work, which keeps them away from care actions and put them in a more managerial and less caregiving profile. They reinforce that managing activities do not exclude care activities. Therefore, there must be a greater integration of activities between nurses and the FHT, with distribution of tasks in a shared and consensual way, so that nurses are not kept away from their essential care competence⁽²¹⁻²²⁾.

The difficulty monitoring and following up children was pointed as an issue in the Culture Circles due to the limited number of CHAs in some micro areas of the territory covered by the PCCs. This difficulty revealed the nurses' concern when considering the CHAs as important allies in the active search of children/families and for the effectiveness of the territoriality and longitudinally care, principles of the Unified Health System, guided by the National Policy of Primary Care (PNAB – *Política Nacional da Atenção Básica*)⁽²⁰⁾.

The new ordinance of PNAB, revised in 2017, states that the number of CHAs can be adjusted according to demographic, epidemiological and socioeconomic criteria. This can restrict the number of these professionals in the FHT. In addition, the policy assigns CHAs other functions, which overlap into the technical capacity of other professionals in the health field⁽²⁰⁾.

This study suggests that the changes implemented in the PNAB only confirm what already happens in the context of the FHS. The nurses in this study report that CHAs are deviated from their function, which is related to the fact that most of them already have a technical nursing course and, consequently, end up abandoning the functions established by the policy. However, this finding contradicts PNAB's proposal to consider the FHS as a priority strategy, since the logic of the Family Health care model is obliterated⁽²⁰⁾.

Another limit situation unveiled by nurses, which is one of the reasons of their difficulty to monitor and follow up

children/families, is the inclusion of up to five FHTs in a single PCC. This is perceived by nurses as a factor that hinders accessibility and bonding to children/families, since the PCCs are geographically distant from the users, reducing the possibility of coordinating health practices with the community, especially with those who are unable to commute. This situation leads to the discontinuity of health practices and corroborates previous studies⁽²³⁻²⁴⁾.

Work focused on productivity was another limit-situation identified, unveiling a reality aggravated by feelings of frustration and demotivation, due to the difficult task of making 12 nursing consultations per shift along with the numerous activities they also perform. Studies provide similar results, emphasizing that the financial support of health actions is still based on quantitative data (number of consultations and procedures) and this contributes to a work practice guided by quantitative goals^(22,25).

The lack of training and the little use of government protocols are also limiting factors in childcare. Care protocols are essential instruments to guide nurses' work. However, they must be used with flexibility, considering the particularities of each reality of childcare. Theoretical and practical training are fundamental for the full insertion of professionals in the care of the child, which can help identifying vulnerabilities and severe situations and support counseling and preparation of families for the continuity of childcare^(12,26).

A better political and institutional coordination from all professionals of the unit is necessary for improving reception practice, which requires preparation and strategic organization of the health team according to the local reality. The reception contributes to the establishment of a bond between the families of the children and the health service, the reorganization of the work process and the expansion of decision-making possibilities⁽²⁷⁾.

The limit-situations unveiled in this study are similar to those identified in many studies that address the difficulties of child health practices in primary care. However, these studies do not provide an opportunity for questioning and reflecting on the practices experienced. The dialogic and reflective approach used in this study contributed to an apprehension of "limit-situations" as challenging situations and not as extraneous and insurmountable problems. In this regard, Freire, when inferring about overcoming limit-situations pointed that, instead of considering them as the extreme of the possibilities, one should see them as a frontier for "being more", while coping with the "limit-acts".

The limit-situations experienced by the participants in this study can compromise the development of actions in child health, such as community therapy, culture circles, therapeutic listening, home visits, health education (lectures and guidelines) and social projects. Studies show that these practices encourage active participation of professionals and families involved in the health care process^(10,28).

Health promotion practices create spaces that bring nursing professionals closer to the families of children, their way of life and the context in which these families are

inserted, establishing an interactional process that includes educational interactions and experiences. Awareness of the knowledge of families completes the scientific knowledge of the nurses and vice versa, creating a liberating and dialogic practice⁽¹⁴⁾.

It is in this perspective that one identifies the potential for empowerment, in an individual sense, in which nurses reflect on the reality of their practices and acquire more control over them, such as community sense, regarding the collective strengthening of control over one's health, improving the quality and conditions of life; and the strengthening of their social environment and actions of collective impact, such as health-promoting practices, based on the strategies of HP in the Ottawa Charter, development of personal skills and reorientation of health services^(15,28).

With empowerment as a structuring element of health promotion, it is possible to see new ways and possibilities to strengthen FHS nurses as more autonomous subjects, with political attitudes and social responsibility for the transformation of their practices in child health care. Thus, studies focusing on this theme should be intensified.

A limitation of this study was not extending this investigation to include the perspective of the other members of the Family Health Strategy team, which would enable a broader and more pertinent understanding of

the guiding questions proposed for discussion in the research itinerary.

CONCLUSION

The nurses' practices in child health care developed in the health units that were part of this investigation are marked by "limit-situations" unveiled in the work process. The thought process of these professionals is often presented as an alienation, provoked by the overload of activities and centralization of responsibilities. This reality poses the impossibility of reaching the strictly stipulated goals of production of quantitative care, arising from a vertical and little participative organizational policy, which, in the nurses' perception, needs to consider the reality experienced by them in the Family Health Strategy.

This study found that the application of Paulo Freire's Research Itinerary was an opportunity for the creation of dialogic spaces with nurses, enabling reflection on their practices in a dynamic process of action-reflection-action and allowing a critical view on the generating themes represented by the "limit situations" unveiled. The combination of the Freirean Itinerary and the perspective of empowerment contributed to strengthening nurses to become more autonomous and acquire greater political and social responsibility to transform their practices in child health care.

RESUMO

Objetivo: Analisar as situações-limite enfrentadas pelos enfermeiros nas práticas de atenção à saúde da criança, na perspectiva do empoderamento na promoção da saúde. **Método:** Pesquisa de abordagem qualitativa, do tipo ação-participante, apoiada no Itinerário de Pesquisa de Paulo Freire, desenvolvida por Círculos de Cultura, constituída de três etapas: Investigação temática, Codificação e Descodificação e Desvelamento crítico. Foram realizados 13 Círculos de Cultura com enfermeiros da Estratégia Saúde da Família de cinco Unidades Básicas de Saúde no município de Manaus, Amazonas. **Resultados:** Participaram 16 enfermeiros. Emergiram dos Círculos de Cultura 20 temas geradores, seis deles considerados pelos participantes pertinentes às situações-limite: acúmulo de atividades, dificuldade de monitoramento e acompanhamento das crianças, trabalho centrado na produtividade, falta de capacitação, limitação de recursos humanos, dificuldade de acolhimento. **Conclusão:** O estudo contribuiu para fortalecimento dos enfermeiros a partir de diálogos reflexivos quanto à realidade vivenciada, possibilitando tomada de consciência e intervenções para a transformação de suas práticas na atenção à saúde da criança.

DESCRITORES

Empoderamento para a Saúde; Saúde da Criança; Enfermagem Pediátrica; Enfermagem de Atenção Primária; Promoção da Saúde.

RESUMEN

Objetivo: Analizar las situaciones límite a las que se enfrentan los enfermeros en las prácticas de atención sanitaria infantil, desde la perspectiva del empoderamiento de la promoción de la salud. **Método:** Se trata de una investigación de enfoque cualitativo, del tipo acción-participante, apoyada por el Itinerario de Investigación de Paulo Freire, desarrollado por Círculos de Cultura, que consta de tres etapas: Investigación temática, Codificación y Decodificación y Develación Crítica. Se realizaron 13 Círculos de Cultura con enfermeros de la Estrategia de Salud Familiar de cinco Unidades Básicas de Salud en la ciudad de Manaus, Amazonas. **Resultados:** Participaron 16 enfermeros. De los Círculos de Cultura surgieron veinte temas generadores, seis de los cuales fueron considerados por los participantes como pertinentes a las situaciones límite: acumulación de actividades, dificultad de monitoreo y seguimiento de los niños, trabajo centrado en la productividad, falta de formación, limitación de los recursos humanos, dificultad de acogida. **Conclusión:** El estudio contribuyó al fortalecimiento de los enfermeros a partir de diálogos reflexivos sobre la realidad vivida, lo que posibilita la toma de conciencia e intervenciones para la transformación de sus prácticas en la atención de la salud infantil.

DESCRIPTORES

Empoderamiento para la Salud; Salud del Niño; Enfermería Pediátrica; Enfermería de Atención Primaria; Promoción de la Salud.

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