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NURSES' ACTIONS AND ARTICULATIONS IN CHILD CARE IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: to understand the configurations of nursing care for children under five in Family Health Units, focusing on comprehensive health care.

Method: qualitative research. Data were collected through a semistructured interview with 26 nurses, in a city in the State of São Paulo, between June 2013 and January 2014, and submitted to thematic content analysis.

Results: two categories were elaborated. In the first, "The practice of child care: contributions of nursing", some actions were listed for comprehensive care, and the child's understanding was valued as a singular subject in the family and community context. The category "Support networks: weaving actions and articulations for access and comprehensiveness of child care" revealed the nursing consultation as a valuable instrument for nurses, for whom the availability of other sectors and health services to care for the children in their needs makes comprehensive care possible. The importance of access to actions that seek to improve children's quality of life and reduce potential risks to their growth and development was also stressed.

Conclusion: as a contribution, the actions of nurses indicate ways for the comprehensiveness of care, corroborating current public policies. It is imperative that such actions be valued and transmitted to care settings that still lack comprehensive health care for children and their family, thus fulfilling commitments indicated in the agendas for this clientele.

DESCRIPTORS: Primary health care. Integrality in health. Child care. Pediatric nursing. Comprehensive health care.

AÇÕES E ARTICULAÇÕES DO ENFERMEIRO NO CUIDADO DA CRIANÇA NA ATENÇÃO BÁSICA

RESUMO

Objetivo: compreender como se configura a assistência de enfermagem a crianças menores de cinco anos em Unidades de Saúde da Família, com foco na integralidade do cuidado.

Método: pesquisa de abordagem qualitativa. Os dados foram coletados mediante entrevista semiestruturada com 26 enfermeiras, em um município paulista, entre junho de 2013 e janeiro de 2014, e submetidos a análise de conteúdo, modalidade temática.

Resultados: construídas duas categorias. Na primeira, "A prática do cuidado da criança: contribuições da enfermagem", algumas ações foram elencadas para alcance do cuidado integral, e valorizou-se a compreensão da criança como sujeito singular no contexto familiar e comunitário. A categoria "Redes de apoio: tecendo ações e articulações para o acesso e a integralidade do cuidado da criança" revelou a consulta de enfermagem como instrumento de valor às enfermeiras, para as quais a disponibilidade de outros setores e serviços de saúde para atender a criança em suas necessidades viabiliza um cuidado integral. Ressaltou-se ainda a importância do acesso a ações que buscam melhorar a qualidade de vida das crianças e reduzir potenciais riscos para seu crescimento e desenvolvimento.

Conclusão: como contribuição, tem-se que as ações das enfermeiras sinalizam caminhos para a integralidade do cuidado, corroborando políticas públicas atuais. Faz-se premente que tais ações sejam valorizadas e transmitidas a cenários de cuidado que ainda carecem de assistir a criança e sua família integralmente e, assim, cumprir compromissos apontados nas agendas destinadas a esta clientela.

DESCRITORES: Atenção primária à saúde. Integralidade em saúde. Cuidado da criança. Enfermagem pediátrica. Assistência integral à saúde.

ACCIONES Y ARTICULACIONES DEL ENFERMERO EN EL CUIDADO DEL NIÑO EN LA ATENCIÓN BÁSICA

RESUMEN

Objetivo: comprender cómo se configura la asistencia de la enfermería para niños menores de cinco años en Unidades de Salud de la Familia y enfocando en la integralidad del cuidado.

Método: investigación de abordaje cualitativa. Los datos fueron obtenidos mediante entrevista semiestructurada con 26 enfermeras, en un municipio paulista, entre Junio del 2013 y Enero del 2014, y fueron sometidos a un análisis de contenido en la modalidad temática.

Resultados: fueron **c**onstruidas dos categorías. En la primera, "La práctica del cuidado del niño: contribuciones de la enfermería", algunas acciones fueron incluidas para el alcance del cuidado integral y se valorizó la comprensión del niño como sujeto singular en el contexto familiar y comunitario. La categoría "Redes de apoyo: tejiendo acciones y articulaciones para el acceso y la integralidad del cuidado del niño" reveló la consulta de enfermería como instrumento de valor para las enfermeras que disponiendo de otros sectores y servicios de salud para atender al niño y sus necesidades viabilizan un cuidado integral. Además, se destacó la importancia del acceso a las acciones que buscan mejorar la calidad de vida de los niños y reducir potenciales riesgos para su crecimiento y desarrollo.

Conclusión: como contribución, las acciones de las enfermeras señalan caminos para la integralidad del cuidado y corroborando las políticas públicas actuales. Es necesario que tales acciones sean valorizadas y transmitidas a los escenarios del cuidado que todavía carecen de asistencia para el niño y su familia integralmente y, así, cumplir con los compromisos establecidos en las agendas destinadas a esta clientela.

DESCRIPTORES: Atención primaria para la salud. Integralidad en salud. Cuidado del niño. Enfermería pediátrica. Asistencia integral para la salud.

INTRODUCTION

Child health care has been based on the guidelines of Brazilian and international public health care policies for this clientele and seeks to guide the care so that it is offered in a comprehensive and problem-solving manner. At the Brazilian level, transformations have occurred since the late 1980s, when the child was provided with policies and programs that were aimed at expanding the access to health services and ensure comprehensive care that encompassed the family and the environment they lived in.[1] In the decades of 2000 and 2010, official Brazilian documents pursued the consolidation of child health care, which contributed to reinforce the need for timely access to services, health care and, above all, comprehensive care.[2]

Another important event dates back to November 2014, when the National Health Council approved the National Policy on Comprehensive Health Care for the Child (PNAISC), published in August 2015 through Decree 1.130, with the objective of systematizing and articulating different actions, programs and policies on child health. As a milestone in the definition of policies aimed at children, it also aims to shape the care for this population from the perspective of network care, in order to transform and further strengthen the potential of health care services, so that appropriate child care is possible.[2-3]

Thus, Brazil, also a signatory to international agreements, seeks to qualify care in order to achieve increasingly positive outcomes in child health, such as the reduction of child mortality, Millennium Development Goal 4, achieved in the country two years before the globally established deadline.[4] The improvement in Brazilian child health indicators is attributed to social and economic changes, together with government actions and programs that have expanded access to and coverage of health services, especially in Primary Health Care (PHC).[4-5]

A recent World Health Organization (WHO) document stresses the importance of universal health coverage and introduces the pressing issue of equity and justice not only in health, but also in access to health care actions and services.[6]

As an important goal of health systems, the authors point to the implementation of universal health coverage and universal access to health, with emphasis on the broad access to PHC, through the acknowledgement that people and communities should have equitable access to quality health services throughout the life cycle.[7] Nurses also have the capacity to offer better care in PHC in order to contribute to changes in health indicators, such as the reduction of morbidity and mortality through the development of health promotion actions, prevention of illness, treatment, rehabilitation and palliative care.[7] To this end, professionals need to be qualified to act through an advanced practice with specialized knowledge, in order to make complex decisions based on clinical competences for care within their reality and activity area.[7]

The Family Health Strategy (FHS), in the context of child care, shows an important space for promoting the approximation between the health team and the caregiver / family, interweaving possibilities of access to services and to efficient and effective care for health maintenance.[8-11]

Formed by a multiprofessional team, the FHS aims to offer health care to a population within a given territory. The nurse, as a member of this team, has a relevant role to achieve some of the doctrinal principles of the Unified Health System (SUS). Nurses perform nursing consultations and evaluate the health status of each user.[12] Therefore, they need a holistic view of care, so that they can identify and highlight the main health problems of the population, as well as seek tools to work with these issues.[10,12-13]

In this context, it is emphasized that the evaluation of child growth and development is another responsibility of this professional, and can be performed during the consultation at the health service or during the home visit.[14] Through the implementation of the nursing consultation in health services, the nurses' work becomes continuous and characterized as a general care strategy focused on the life cycle and family care.[15]

The effectiveness of health care presupposes the comprehensiveness of actions, a principle that has been addressed in governmental recommendations[2] and refers to the right of the children to be assisted properly, and with quality, in all their needs,[16] through organized health services, at all levels of care.[2,16]

In this sense, comprehensiveness can be conceived as the integration of actions of promotion, prevention, healing and rehabilitation, through the work process; as a professional practice, in which the individuals are considered in the biological and psychological entirety, adding the environment they live in.[17-18] It can also be conceived as the organization of services, in order to provide continuity of care, access to technological devices that enable the resolution of health problems, and articulation of policies that allow for shared intersectoral and management actions.[17-18]

Despite the different conceptions, it is important to point out that studies have indicated fragilities in the aspects that involve comprehensive care, whether in the availability of health care services and sectors when the child presents needs, or through the care that remains based on the biological model, not understanding that children are influenced by their family and the context they live in.[19-22] This care is often fragmented, without interlocution between sectors and services,[23] and with little interaction and communication between professionals and family.[24-25]

Nevertheless, a path can be outlined that considers comprehensiveness, an essential aspect for care, which takes place as the children are understood in their entirety, in the family and community context, taking into account the issues that form and shape them as individuals, with respect for their singularities. It is also necessary to incorporate the knowledge and practices of professionals, which contribute for the health actions to take place (materialize) in a qualified way, with a view to achieving the resolution of needs at the different levels of health service complexity.

Thus, understanding the importance of health care offered to children and of the FHS as a care model that seeks to provide quality primary care according to SUS principles, this study raises the question: Does nursing care for children under five in the FHS encompass comprehensiveness? The objective was to understand, in the nurses' view, the configurations of care for children under five years old in Family Health Services, focusing on care comprehensiveness.

METHOD

Study with a qualitative approach, carried out between June 1, 2013 and January 31, 2014, in all Family Health Services of Ribeirão Preto, SP. Regarding the services of the municipal health network, Ribeirão Preto, at the time of data collection, had 28 Basic Health Units, 15 Family Health Services, a Pediatric Primary and Specialized Care Services, five Primary Districts Health Services and 12 Specialized Services. It is noteworthy that five of the Family Health Services in the city were linked to a Teaching Health Center of a state-owned public university, with six Family Health teams. The remaining 10 Family Health Services were linked to the Municipal Health Department (SMS-RP) and had 24 Family Health teams, totaling 30 teams in the city.

The choice of the Family Health Services as a research scenario is justified by the fact that such services have a child nurses' consultation agenda to monitor the child's growth and development. The Basic Health Services in the city offer the traditional model of care and only provide nurses' services to children in response to specific needs, such as neonatal screening and care in the first week of life.

The 30 nurses from the 15 Family Health Services were invited to participate in the study, with the participation of 26 nurses, as three refused the invitation and one was on vacation during the data collection period at the services.

As a data collection technique, the semi-structured interview was used. Initially, the main researcher made prior telephone contact with the nurses and arranged a meeting so that the research could be explained in detail. During the face-to-face meeting, the researcher invited them to participate in the study and, upon acceptance, the best days and times for the interview were agreed upon. Some were held on the same day and others scheduled for a later date.

At a private room inside the Family Health Service, after the signing of the Informed Consent Term (TCLE), interviews were conducted by the principal investigator, with experience in the area, and also by a research assistant (undergraduate student), after training. To begin the data collection, a two-part script was used: the first part considered the time since graduation, including complementary education, the length of experience, as well as the qualification for child care in the Family Health Strategy. The second was driven by the following guiding question: what are the actions you take in care for children under the age of five? Supporting questions sought information about how this child care took place (nursing consultation) and about the inherent facilities and difficulties. The topics were intended to encourage nurses to talk about the care they have provided to children from their first attendance at the Family Health Service, since birth until the age of five years, taking care not to interfere in the interview.

There was only one meeting with each participant and the interviews lasted approximately 30 minutes, being recorded in digital media and complemented by field notes, a document used to register non-recordable information.

For the data analysis, the interviews were transcribed in full and followed the steps of thematic content analysis.[26] In the first phase, called pre-analysis, hypotheses were elaborated based on the floating reading of the interviews, with construction of indicators that supported the interpretation. The second phase, exploration of the material, consisted in the codification of the raw data from the text. In the last phase, there was data processing, inference and interpretation, through the Categorization of Data, which were discussed based on the literature and analyzed in the light of comprehensive care.

The project received approval from the Research Ethics Committee (CAAE 11617213.5.0000.5393; Opinion 115/2013) and all ethical precepts for research involving human subjects were complied with. Participants were identified using the letter E, followed by a number corresponding to the order of interviews.

RESULTS

All nurses interviewed are female, aged 25 to 56 years, and completed the undergraduate nursing course between 1980 and 2008. Before working in the Family Health Services where they were working at the moment of data collection, all reported experience in primary care as well as in hospital care. With regard to training, 20 nurses held a Specialization Degree in Family Health; seven had completed an academic master's degree and three were taking a Master's program at the time of the interview. Two nurses were enrolled in a Ph.D. and one already held a Ph.D. The majority referred training to work in the FHS and 23 nurses stated that they participated in events involving child health topics, especially neonatal screening, breastfeeding and infant feeding.

Based on the data analysis, two categories were constructed: "The practice of child care: contributions of nursing", which addresses the actions nurses develop in child care; and "Support networks: weaving actions and articulations for the comprehensiveness of child care", which reveals the articulations between sectors and services to put child care in practice.

The practice of child care: nursing contributions

Nursing care for children under five years in the FHS involves health actions directly related to care, such as physical examination, collection of material for examination and immunization, and others related to breastfeeding, infant feeding and guidelines about the prevention of accidents.

This care begins the first time the child is attended at the Family Health Service, through the nursing consultation, scheduled in the maternity ward. Because it is the child's first contact with the health service, it is considered the gateway to the service and the framework of care that begins after birth, as can be seen in some statements: [...] *it starts with the nursing consultation, which is the framework for all this and then, this nursing consultation starts with the first attendance in the first days of life* (E6).

It begins at birth. The first consultation of the child is scheduled with the nurse, the new case of child care [...]

there, we collect neonatal screening test and attend the child for the first time, an actual nursing consultation, physical examination, besides the neonatal screening test, vaccine. We also consult the mother, the postpartum woman, if she is having difficulty in breastfeeding [...] *That's how we start!* (E8).

We are the gateway, after the maternity, for the child, right?! It is scheduled by the hospital or else, we attend on demand to collect the neonatal heel prick and, when we do so, we already do the first child care consultation (E9).

In the discourse, the nurses emphasize the importance of access to health services right after birth, in order to take care of the newborn. *Here, we do the first child care consultation, the child's appointment with the nurse was already scheduled at the maternity hospital. We do the evaluation, weight, height, physical examination, right?! Vaccination, if the child had hepatitis B in the maternity ward, if the eyes and ears were tested. Then, we provide all the orientations. See if the baby is latching on well* [breastfeeding] [...] *guide the mother about all breastfeeding care* (E24).

The nurses stress that mother and child are not detached at such an important moment in their lives. *I welcome the binomial here at the Service and then we start monitoring the development, mainly* (E2).

Investigating the umbilical stump with the mother, orientation about exposure to the sun, breastfeeding [...] *this consultation is for the binomial. We already look at the breast in case the mother has some difficulty. I like to try to see a breastfeeding session, especially if she says that she has some problem with breastfeeding or if her breast is damaged* (E21).

Another important aspect identified in the reports is the exchange of experiences and knowledge between nurse and doctor. If in doubt, the nurse consults the physician and, when necessary, the doctor forwards the child for nursing care. An example of articulation among professionals that has resulted in benefit for the child is the investment in guidelines and support for breastfeeding. *We can detect many important things, because we have access to the pediatrics team so that, at that moment, we can communicate what we have noticed. Often, we have already found very relevant solutions for the problems, the pediatrician ends up interfering at that moment and avoiding any important complications for the child* (E9).

Here we also do work to encourage breastfeeding together with doctors. When they detect some difficulty in breastfeeding, they pass it on to us. We also monitor, do child care control together with the doctor. So, we have even managed to reverse situations of artificial feeding, such as three cases of premature infants we were able to reverse. So, you know, the work is very gratifying (E10).

We have the freedom to contact the physician and try to solve that problem. So, there is very good communication with the medical team, mainly regarding the children (E17).

When thinking about the comprehensiveness of care, the perspective of teamwork is evident, taking into account the diversity existing among the professionals involved in the care of the child. The interactions that will be necessary for this care to take place also need to be understood, even in the face of conflicts and contradictions. It is in this daily construction of the presentation of knowledge and practices that pertinent and timely care will be established for a given situation and that respects the singularities of each child.

The following discourse illustrates this composition for child care. *We work at the doctor's consultation, if* [the child] *is not absent; when they* [children] *come to the dental office. So we make a triangle there. Get the doctor, the nurse and the dental surgeon together, okay?! So we can receive all those kids. Then, the medical appointments begin to get more spaced, each year. You evaluate a delayed vaccination of this child. There, the community agent provides the orientation* [update vaccination] (E15).

Another aspect of care concerns the home visit, which occurs as soon as the mother and baby return from the maternity ward or because of care demands, some related to possible risks for the child.

When the baby is born, I do both a home visit to the binomial, and I welcome the binomial here at the Service (E2).

In some situations, we go home to families with situations in which we identify risk in the family, family and organizational difficulties or in relation to a specific health need (E3).

For all babies who are born, I receive the notification of birth [sent by the Program A Life Flowers], *and I go to the home when necessary* (E4).

Support networks: weaving actions and articulations for access and comprehensiveness of child care

The provision of services and referral to other sectors, when necessary, configure ways to meet the children's needs. Nurses verbalize the importance of a support network to take care of the children in their multiple possibilities, because they understand

that care can only consider care comprehensiveness if health services and social facilities that attend to the children are available and dialogue mutually in an effective and problem-solving manner.

We articulate with the Child Health Program. We can refer the child if we think it is a case of pediatrics that goes beyond Primary Care, which needs to be secondary. There is the partnership of the vaccination room, blood collection at the "Y" [Basic and District Health Service], *which does the Neonatal Heel Prick and applies the vaccines for us as long as we are unable to structure the service* (E2).

The community agent [during home visit] *identifies a child who does not go to school; so we have communicated with the welfare service, the Guardianship Council, or even the Department of Education itself, in the attempt to include this child* [in school] (E5).

The care network offers several health professionals to take care of the child and provides health services and actions that are able to respond to this clientele's specific needs. *For example, the child has a type of difficulty; so, there is the support network, psychologists, nutritionists, because we can refer within the* [Health] *Department, okay?! And there is the Breastfeeding Brazil Network, which I am part of, with a team that gives advice and support to the health units that are part of this network* (E7).

Children born with low Apgar, small for their gestational age, are referred to the PAM[*] for early stimulation. Our children [from the coverage area of the health service] are referred to NADEF[**]. And recently, a baby was born with a cleft lip; then he relies on other entities in the city to keep up with his problem (E11).

We have our little babies who are born prematurely. They go for early stimulation and early stimulation is there at the PAM, but they keep coming here with us, because there's Physio [physiotherapist], *O.T.* [occupational therapist], *right ?!* (E12).

The following statement explains the support network as fundamental for the comprehensiveness of care, with organization of the child care services. *I do not see Family Health if I do not have a support network. No health service today can do without multidisciplinary and interdisciplinary work that goes beyond health. So, besides working with the health services of another complexity level, we also have to articulate with the daycare centers and schools, public and private, with the EMEI's* [Municipal Kindergarten] *in the area. There is the District Health Service "Z"* [name of the District], *the Emergency Care part and part of the UBDS* [Basic and District Health Service], *which is the specialty part. There is no way to work without articulation. You can't work! Even in the team, the nurse does not work alone. So it's a multiple-voice choir, right ?!* (E4).

Among the programs and services offered to children in the city, "A Life Flowers" is cited in several reports as an articulating program that facilitates child care, which assures the attendance to all needs, especially for infants. *We always receive from the hospital, through the A Life Flowers Program, an e-mail notifying that the child was born, Apgar, weight, basic information and scheduling the child's consultation here at the Center, both with me and with the doctor* (E1).

The ease is that here in Ribeirão, because of A Life Flowers, we have a guaranteed appointment, right?! The child already leaves [the maternity ward] *with an appointment with us. So it is something that facilitates access to the health unit for the child and the mother. So we can get this first care faster, this initial evaluation and this makes it easier* [child care] (E6).

The Education sector also emerges as an important partner for the Family Health Service. One of the statements reveals that the contact with daycare centers and schools grants access to health care through health education for children, meeting the demands of the schools, playing an important role, not restricted to a singular perspective, which considers child care as the sole responsibility of the health sector.

This year, through the Health in School Program, we will carry out an anthropometric, visual, audiology and physiotherapeutic evaluation of the children of a Municipal Kindergarten here, which is not even located within our area of coverage, but because the reference health service is being renovated and we got to do it (E6).

DISCUSSION

The training of the nurses in the study to act in the FHS supports studies that point out that the qualification of the nurses allows them to act according to an advanced practice, with positive results in the health of the people,[8] in this case of children.

As from the early access to care after birth, the consultation with the nurse, scheduled at the maternity ward, this is part of the activities of the

[*] Medical Care Service. Municipal outpatient service for care to pediatric specialties.

[**] Care Center for People with Disabilities, affiliated with the Ribeirão Preto Municipal Health Department-SP. At this center, activities of the PRODAF (Health Program for Hearing Impaired and Cleft Patients), Early Stimulation Service and Physiotherapy take place.

A Life Flowers Program.[27] It is an infant health care program offered in the three maternities that attend to SUS users in the city, which has guaranteed infants' access to public health services, proceeding with the care started in prenatal care (at the health service), and also performed upon delivery and in the immediate postpartum (at the maternity).[27-28]

This first care of the mother-child binomial at the service, performed by the nurses, makes it possible to sensitize the mothers about the importance of monitoring their children's growth and development[21,26,29] and also of strengthening the bond and allowing the difficulties for child care to be identified and interventions to be proposed early.[27,30]

The care provided to the binomial reinforces the comprehensive nature of care, as it also considers the mother/caregiver at the moment of the consultation, in line with other studies.[31-32] In this sense, it is essential that nurses recognize and explore the whole opportunity of this meeting with the child and the mother/family to provide care, either by making the appointment or by spontaneous demand to the health service, through a specific complaint.

The integration of knowledge in the team and the recognition that comprehensive care is provided in the whole, rather than in a fragmented way, is identified in the discourse.[8,32] There is a clinical discussion of each child's case, and the joint work with the physician makes it possible to intervene early in order to avoid complications in the child's health and to achieve problem-solving care.

In this sense, a study emphasizes the importance of team integration for the occurrence of comprehensiveness, with respect to the professionals' interdependence for the production of care,[10] which supports the findings in this study. The FHS permits apprehending the individual's overall health through different perspectives and different knowledge, in order to establish a common care plan.[10] In another study, it is emphasized that good relationships among professionals cooperate towards the construction of favorable and fruitful relationships with the mothers.[32]

Therefore, we consider that teamwork favors comprehensive care. The professional's commitment to the service and the search to meet user demands constitute tools for the consolidation of comprehensive practices and the construction of a beneficial relationship,[18,32] in this case for mother and child. The health professionals and services' practice, however, may or may not allow for completeness, and further understanding is needed of how both consider the care they offer.

Teams need to take responsibility for the health care of the population in their area of coverage, in order to coordinate the necessary resources and guide the population about their health problems. In addition, strategies need to be used that integrate different professionals into the team to improve primary health care, with important results for the health of the people as well.[33] The designation of nurses and family physicians into a common practice without any orientation, however, does not produce collaborative practice.[33] In this case, resorting to means to address expectations about the role of each professional facilitates the development of partnerships for the provision of care characterized by independent practices.[9,33]

Collaborative work requires slow progress; in addition, it aids in overcoming professional obstacles, helps to dispel concerns and grants clarity to the roles of each professional and the sense of cooperation.[9,24,33]

One of the actions highlighted, the home visit, corroborates a study that points out its importance as an instrument for the nurses' practice, being a space of possibilities for the nurse to act in defense of the child's right to health.[34]

In reporting that the Family Health strategy needs other services in the network, one interviewee explains how the support network permits the comprehensiveness of care through the organization of the services.[8,20,35] Knowledge of the interdependence among services, sectors and health professionals is observed to provide care to the children's needs.

Referred to as "multi-voiced choir", this articulated work is present in the interrelationship and intersection of multiple knowledge and practices and of diverse and organized sectors and services to act together with the children and enhance what is targeted as the end product - the care - and for it to be truly comprehensive.[8,20,33,35]

Comprehensiveness also needs to permeate the way in which practices are organized (from fragmentation to the whole).[17-18] From this perspective, services need to assume a posture that enables extended care, with the user serving as the protagonist of this process. On the other hand, the health professional needs to be open, in a comprehensive posture, to assimilate the needs that will

arise and offer problem solving,[33] with improved access and integration of the service with other social networks.[18,20]

In some studies, the absence/difficulty of access to secondary services emerges as an obstacle to comprehensiveness.[18,25,36] This, however, differs from the findings of the present study, as the nurses interviewed recognize facilities to trigger services and sectors for child care when they find this necessary.

Referred to by several interviewees, the A Life Flowers program, since its inception in the mid-1990s, has become a unifying strategy that articulates hospitals and primary health care services and aims, above all, to guarantee integral care to the maternal-infant population and to facilitate access to health services and continuity of care.[27]

The education sector was also mentioned. The feasibility of offering care in an expanded sense, through the interrelations of sectors and health services,[8,37] permits focusing on the true needs of the population, with articulated and complementary actions.[2,16,28,37]

Despite considering that the statements point to a harmonious articulation between sectors and services, it should be kept in mind that there are still challenges to be overcome and that they include the need to improve the management of care, as well as to qualify the agreement of responsibilities.[20,37] The qualification of PHC also needs to be reflect on by strengthening the coordination of care and ordering its continuity at the different levels of care.

Comprehensiveness is seen as one of the most challenging principles of the Unified Health System (SUS),[38] which implies rethinking the health actions in different dimensions, including the organization of health care, the intersubjective interactions and work in networks, with a view to overcoming the fragmentation of care and health management in order to produce comprehensive care.[38]

CONCLUSION

In this study, the actions were identified which nurses perform in the care for children under five in the Family Health Strategy from the perspective of comprehensive health care. Important aspects of this study support the strengthening of health care for these clients, which are not only focused on techniques such as weight and height verification, neonatal screening test and immunization, but also on the appreciation of the child as a singular subject and on interventions in the family and community context, with a view to reaching comprehensive care.

Nurses demonstrate an understanding of their practice as a framework for care and of their articulating role in the multiprofessional team and in the care network, as a way to foster access to comprehensive care. The interpersonal relationship with the other professionals evidenced that the nurse works in a team, and needs to share knowledge to put in practice the care provided to the child and the expand the access. The nursing consultation, as an instrument of value for the nurse, proved to be fruitful to attend to the child's needs. The professionals perceive this care as essential to bring the mother and family closer to the health unit, because it enables them to establish partnerships capable of achieving qualified care.

The availability of health sectors and services to meet the needs of the child, according to the nurses, facilitates the provision of comprehensive care, with access to health actions that seek to improve the child›s quality of life, reducing vulnerabilities for the child›s growth and development.

The limitations of this study relate to the fact that the coverage of the FHS in the city's primary health care services is limited, with results that cannot be generalized to the city as a whole. Nevertheless, the research scenario presented here, points out ways that permit the comprehensive child care.

The results are relevant to the study of the care for children and their families and generate aspects to be investigated in new research in different scenarios, in accordance with the commitments made in the agendas of public health policies aimed at this clientele.

REFERENCES

1. Gomes ES, Costa Filho J. Historicidade da infância no Brasil. El Futuro del Pasado. [Internet]. 2013 [cited 2015 Dec 10]; 4. Available from: http://www.elfuturodelpasado.com/ojs/index.php/FdP/article/view/149/140
2. Furtado MCC, Mello DF, Pina JC, Macedo JCB. Atuação da enfermagem nas redes de atenção à criança. In: Associação Brasileira de Enfermagem; Kalinoswki CE, Crozeta K, organizadores. PROENF Programa de Atualização em Enfermagem: Atenção Primária e Saúde da Família: Ciclo 3. Porto Alegre

(RS): Artmed Panamericana; 2015. p.41-82. (Sistema de Educação Continuada à Distância, v.4).

3. Ministério da Saúde (BR). Portaria nº 1.130 de 05 de agosto de 2015. Institui a Política Nacional de Atenção Integral à Saúde da Criança e do Adolescente no âmbito do SUS [Internet]. 2015 [cited 2015 Dec 01]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt1130_05_08_2015.html
4. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Maternal and child health in Brazil: progress and challenges. Lancet [Internet]. 2011 [cited 2015 Nov 05]; 377(9780):1863-76. Avalialbe from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60138-4/abstract
5. Pedro M, Rodrigues D, Silva D. Saúde é o que interessa? A influência do PSF no alcance da meta de redução da mortalidade infantil dos Objetivos do Desenvolvimento do Milênio (2000-2011). Pol. Hoje [Internet]. 2016 [cited 2017 Mai 23]; 25(2):175-212. Available from: https://periodicos.ufpe.br/revistas/politicahoje/article/view/3863
6. Noronha JC. Universal health coverage: how to mix concepts, confuse objectives, and abandon principles. Cad Saúde Pública [Internet]. 2013 [cited 2015 Oct 28]; 29(5):847-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2013000500003
7. Cassiani SHB, Zug KE. Promoting the advanced nursing practice role in Latin America. Rev Bras Enferm [Internet]. 2014 [cited 2015 Oct 27]; 67(5):675-6. Available from: http://www.scielo.br/scielo.php?pid=S0034-71672014000500673&script=sci_arttext&tlng=pt
8. Alvim NAT. Health under integrality perspective. Esc Anna Nery [Internet]. 2013 [cited 2015 Nov 10]; 17(4):599-601. Available from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452013000400599
9. Viegas SMF, Penna CMM. The construction of integrality in the daily work of health family team. Esc Anna Nery [Internet]. 2013 [cited 2015 Nov 05]; 17(1):133-41. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452013000100019
10. Silva DI, Veríssimo MDLOR, Mazza VM. Vulnerability in the child development: influence of public policies and health programs. J Hum Growth and Development [Internet]. 2015 [cited 2017 Mai 23]. Available from: http://www.revistas.usp.br/jhgd/article/view/96760
11. Shah R, Kennedy S, Clark MD, Bauer SC, Schwartz A. Primary care-based interventions to promote positive parenting behaviors: a meta-analysis. Pediatr [Internet]. 2016 [cited 2017 Mai 22]; 137(5):e20153393. Avaliable from: http://pediatrics.aappublications.org/content/pediatrics/early/2016/04/16/peds.2015-3393.full.pdf
12. Yakuwa MS, Andrade RD, Wernet M, Fonseca LMM, Furtado MCC, Mello DF. Nurse´s knowledge in child health primary care. Texto Contexto Enferm. [Internet]. 2016 [cited 2017 Mai 23]; 25(4):e2670015. Avaliable from: http://www.scielo.br/pdf/tce/v25n4/pt_0104-0707-tce-25-04-2670015.pdf
13. Ribeiro DG, Perosa GB, Padovani FHP. Risk factors for impaired development in children attended at Family health units at the end of the first year of life: socio-demographic aspects and maternal mental health. Ciênc Saúde Colet. [Internet]. 2014 [cited 2017 Mai 23]; 19(1):215-26. Available from: http://www.scielo.br/pdf/csc/v19n1/1413-8123-csc-19-01-00215.pdf
14. Radcliffe J, Schawrz D, Zhao H. The MOM Program: home visiting in partnership with pediatric care. Pediatr [Internet] 2013 [cited 2017 Mai 23];132(2):S153-9. Available from: http://pediatrics.aappublications.org/content/pediatrics/132/Supplement_2/S153.full.pdf
15. Gasparino RF, Simonetti JP, Tonete VLP. Consulta de enfermagem pediátrica na perspectiva de enfermeiros da Estratégia Saúde da Família. Rev Rene [Internet]. 2013 [cited 2016 Jan 10]; 14(6):1112-22. Available from: http://www.revistarene.ufc.br/revista/index.php/revista/article/viewFile/1342/pdf_1
16. Andrade RD, Santos JS, Pina JC, Furtado MCC, Mello DF. Integrality of actions among professional and services: a necessity for child´s right to health. Esc. Anna Nery [Internet]. 2013 [cited 2016 Jan 06]; 17(4):772-80. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452013000400772
17. Paim, JS, Silva LMV. Universalidade, integralidade, equidade e SUS. Bol Inst Saúde [Internet]. 2010 [cited 2017 Mai 23]; 2(2). Availabe from: http://periodicos.ses.sp.bvs.br/scielo.php?script=sci_arttext&pid=s1518-18122010000200002&lng=pt&nrm=iso
18. Andrade SR, Mello ALSF, Locks MTR, Hoeller F, Erdmann AL. Best practices in primary healthcare and meanings of integrality. Rev Esc Anna Nery [Internet]. 2013 [cited 2017 Mai 23]; 17(4):620-7. Available from: http://www.scielo.br/pdf/ean/v17n4/1414-8145-ean-17-04-0620.pdf

19. Vaz EMC, Magalhães RKBP, Toso BRGO, Reichert APS, Collet N. Longitudinality in childcare provided through Family Health Strategy. Rev Gaucha Enferm [Internet]. 2015 [cited 2017 Mai 22]; 36(4):49-54. Available from: http://www.scielo.br/pdf/rgenf/v36n4/pt_1983-1447-rgenf-36-04-00049.pdf

20. Diniz SGM, Damasceno SS, Coutinho SED, Toso BRGO, Collet N. Evaluating comprehensiveness in children´s healthcare. Rev Gaucha Enferm [Internet]. 2016 [cited 2017 Mai 23]; 37(4):e57067. Available from: http://www.scielo.br/pdf/rgenf/v37n4/0102-6933-rgenf-1983-144720160457067.pdf

21. Carvalho EB, Sarinho SW. The nursing consultation in monitoring child growth and development in the Family Health Strategy. Rev Enferm UFPE. [Internet]. 2016 [cited 2017 Mai 23];10(supl6):4804-12. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/9069

22. Santos NCCB, Toso BRGO, Collet N, Reichert APS. Family-centeredness and community orientation according to three child health care models. Acta Paul Enferm. [Internet]. 2016 [cited 2017 Mai 23]; 29(6):610-7. Available from: http://www.scielo.br/pdf/ape/v29n6/1982-0194-ape-29-06-0610.pdf

23. Aires LCP, Santos EKA, Bruggemann OM, Backes MTS, Costa R. Reference and counter-reference health care system of infant discharged from neonatal unit: perceptions of primary health professionals. Esc Anna Nery [Internet]. 2017 [cited 2017 Mai 23]; 21(2):e20170028. Available from: http://www.scielo.br/pdf/ean/v21n2/1414-8145-ean-21-02-e20170028.pdf

24. Coriolano-Marinus MWL, Andrade RS, Ruiz-Moreno L, Lima LS. Communication of health care workers and users in caring for children under two years old in the context of a Family health unit. Interface [Internet]. 2015 [cited 2017 Mai 24]; 19(53). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832015000200311&lng=pt&nrm=iso&tlng=pt

25. Silva SA, Fracolli LA. Evaluating child care in the Family Health Strategy. Rev Bras Enferm [Internet]. 2016 [cited 2017 Mai 23]; 69(1):54-61. Available from: http://www.scielo.br/pdf/reben/v69n1/0034-7167-reben-69-01-0054.pdf

26. Bardin L. Análise de conteúdo. 1ª ed. São Paulo: Edições 70, 2011.

27. Lima PR, Furtado MCC, Reis MCG, Mello DF, Pina JC. Newborn access and care in a health attention program. Rev Eletr Enferm [Internet]. 2016 [cited 2017 Mai 24];18:e1156. Available from: https://revistas.ufg.br/fen/article/view/31930

28. Furtado MCC, Mello DF, Parada CGL, Pinto IC, Reis MCG, Scochi CGS. Avaliação da atenção ao recém-nascido na articulação entre maternidade e rede básica de saúde. Rev Eletr Enf [Internet]. 2010 [cited 2016 Jan 05]; 12(4):640-6. Available from: https://www.fen.ufg.br/fen_revista/v12/n4/pdf/v12n4a07.pdf

29. Souza MHN, Paz EPA, Farias SNP, Ghelman LG, Matos CX, Barros RR. Integrality as a dimension of nursing practice in mother-baby welcoming. Esc Anna Nery [Internet]. 2013 [cited 2016 Jan 06]; 17(4):677-82. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452013000400677

30. Coker TR, Chacon S, Elliot MN, Bruno Y, Chavis T, Biely C et al. A parent coach model for well-child care among low-income children: a randomized controlled trial. Pediatr [Internet]. 2016 [cited 2017 Mai 23]; 137(3):e201553013. Available from: http://pediatrics.aappublications.org/content/pediatrics/early/2016/02/08/peds.2015-3013.full.pdf

31. Benicio AL, Santana MDR, Bezerra IMP, Santos RR. Care to the child less than one year old: nursing practice perspective about child care. Rev Enferm UFPE [Internet]. 2016 [cited 2017 Mai 23]; 10(2):576-84. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/7095

32. Reichert APS, Rodrigues PF, Albuquerque TM, Collet N, Minayo MCS. Bond between nurses and mothers of children younger than two years old: perceptions of nurses. Ciênc Saúde Colet [Internet]. 2016 [cited 2017 Mai 24]; 21(8):2375-82. Available from: http://www.scielo.br/pdf/csc/v21n8/1413-8123-csc-21-08-2375.pdf

33. Silva MM, Budó MLD, Resta DG, Silva SO, Ebling SBD, Carvalho SORM. The entire Family health; limits and possibilities in view of the team. Cienc Cuid Saúde [Internet]. 2013 [cited 2015 Dec 15]; 12(1):155-63. Available from http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/21736

34. Andrade RD, Santos JS, Maia MAC, Silva MAI, Veríssimo MLOR, Mello DF. Home visit: care technology used by nurses to advocate for child´s health. Texto Contexto Enferm [Internet]. 2015 [cited 2016 Jan 28]; 24(4):1130-8. Available from: http://www.scielo.br/pdf/tce/v24n4/0104-0707-tce-201500000120015.pdf

35. Schadewaldt V, McInnes E, Hiller JE, Gardner A. Views and experience of nurse practitioners and

medical practitioners with collaborative practice in primary health care: an integrative review. BMC Fam Pract [Internet]. 2013 [cited 2016 Jan 10]; 5(14):132-43. Available from: https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-14-132

36. Zuckerman KE, Perrin JM, Hobrecker K, Donelan K. Barriers to specialty care and specialty referral completion in the community health center setting. J Pediatr [Internet]. 2013 [cited 2016 Jan 10]; 162(2):409-14. Available from: http://www.jpeds.com/article/S0022-3476(12)00800-1/pdf

37. Rodrigues LBB, Silva PCS, Peruhype RC, Palha PF, Popolin MP, Crispim JA et al. A atenção primária à saúde na coordenação das redes de atenção: uma revisão integrativa. Cienc Saúde Colet [Internet]. 2014 [cited 2016 Jan 05]; 19(2):343-52. Available from: http://www.scielo.br/pdf/csc/v19n2/1413-8123-csc-19-02-00343.pdf

38. Kalichman AO, Ayres JRCM. Comprehensiveness and healthcare technologies: a narrative on conceptual contributions to the construction of the comprehensiveness principle in the Brazilian Unified National Health System. Cad Saúde Pública [Internet]. 2016; [cited 2017 Mai 23]; 32(8):e00183415. Available from: http://www.scielo.br/pdf/csp/v32n8/1678-4464-csp-32-08-e00183415.pdf

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