

## Contribution of a shelter-based Integrated Management of Childhood Illnesses Program for children under the age of five years\*

*Contribuições da estratégia Atenção Integrada às Doenças Prevalentes na Infância ao acolhimento de crianças menores de cinco anos*

*Contribuciones de la estrategia Atención Integrada a las enfermedades Prevalentes en la Infancia a la acogida de niños menores de cinco años*

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### ABSTRACT

**Objective:** To describe the contribution of a shelter-based integrated management of childhood illnesses program for children under the age of five years from a family health unit. **Methods:** The study was descriptive. Data were collected from 30 children by a nurse and two licensed practical nurses through participant observation using a guide and field diary. **Results:** The three themes identified were: communication and promotion of bond; anamnesis, clinical assessment, and problem solving, which showed that clinical assessment was the focus of nursing contribution; and utilization of the growth curve and assessment of eating habits need to be further explored. In addition to the children's chief complaints, there were opportunities for identification of needed care priorities and other health problems. **Conclusion:** The shelter-based integrated management of childhood illnesses program contributed to the interdisciplinary work in providing adequate care to the sample of children who participated in this study.

**Keywords:** Child health; Integrated management of childhood illness; User embracement; Primary health care

### RESUMO

**Objetivo:** Descrever o acolhimento, estruturado pela Atenção Integrada às Doenças Prevalentes na Infância, às crianças menores de cinco anos, em unidade de saúde da família. **Métodos:** Estudo descritivo. Dados coletados por observação participante durante acolhimento realizado por uma enfermeira e duas auxiliares de enfermagem a 30 crianças, com roteiro e diário de campo. **Resultados:** Os três temas encontrados - comunicação e atitudes promotoras de vínculo; anamnese e avaliação clínica e resolutividade - demonstraram que: a atuação desses profissionais de enfermagem foi maior na avaliação da criança; a utilização do gráfico de crescimento, levantamento de hábitos de saúde e alimentares necessitam ser melhor explorados; foram identificadas as situações prioritárias e outros problemas além da queixa inicial. **Conclusão:** Houve contribuições ao trabalho em equipe para manejo adequado dos casos e organização do acolhimento às crianças.

**Descritores:** Saúde da criança; Atenção integral às doenças prevalentes na infância; Acolhimento; Atenção primária à saúde

### RESUMEN

**Objetivo:** Describir la acogida, estructurada por la Atención Integrada a las enfermedades Prevalentes en la Infancia, a los niños menores de cinco años, en una unidad de salud de la familia. **Métodos:** Estudio descriptivo cuyos datos fueron recolectados por observación participante durante la acogida realizada por una enfermera y dos auxiliares de enfermería a 30 niños, con la utilización de una guía y diario de campo. **Resultados:** Los tres temas encontrados - comunicación y actitudes promotoras de vínculo; anamnesis y evaluación clínica y resolutividad - demostraron que: la actuación de esos profesionales de enfermería fue mayor en la evaluación del niño; la utilización del gráfico de crecimiento, identificación de hábitos de salud y alimenticios necesitan ser mejor explorados; fueron identificadas las situaciones prioritarias y otros problemas además de la queja inicial. **Conclusión:** Hubo contribuciones al trabajo en equipo para el manejo adecuado de los casos y organización de la acogida a los niños.

**Descriptores:** Salud del niño; Atención integrada a las enfermedades prevalentes de la infancia; Acogimiento; Atención primaria de salud

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## INTRODUCTION

In child health, reduction in child mortality has been a great challenge for managers, health professionals and society as a whole<sup>(1)</sup>. Among the causes of child death, communicable diseases have been responsible for up to 70% of deaths in the most impoverished parts of the world<sup>(2)</sup>. In addition, they represent up to a third of all the hospitalizations of children under five years of age in the Americas<sup>(3)</sup>. Such diseases can be avoided through the improvement of the population's life conditions and availability of actions effective for prevention, early diagnosis and treatment.

In Brazil, there has been a decrease in child mortality and this reduction is an important goal. Between 1994 and 2004, there was a 32.6% decrease; in 2004, the most recent year of the estimate, mortality reached 26.6 deaths per 1,000 live newborns<sup>(4)</sup>. However, it is worth emphasizing that there are regional differences, because coefficients are higher in the Northern and Northeast regions, in addition to the differences existing in one region alone.

Comprehensive child care goes beyond the concern about child mortality reduction, involving the mutual commitment between governmental institutions and society in favor of child quality of life.

The concept of integrated child health care actions was the basis for the World Health Organization (WHO), the Pan American Health Organization and the United Nations Children's Fund (UNICEF) to develop a global child health initiative, the Integrated Management of Childhood Illness – IMCI<sup>(5)</sup>.

This strategy appeared as a child health care methodology in accordance with primary health care, proposing a systematic assessment of the key factors affecting child health, integrating healing actions with promotion and preventive measures, and seeking service quality<sup>(6-7)</sup>.

In Brazil, child health has a profile that is closely associated with offering, the population as a whole, and basic life conditions, such as health service quality and availability, food, housing, education, family income, basic sanitation, environmental conditions, leisure, and transportation<sup>(8)</sup>. In this sense, the IMCI strategy focuses on the need for an integrated health approach of Brazilian children.

The IMCI strategy was adopted in Brazil in 1996, in accordance with the WHO's and UNICEF's proposal, aiming to reduce mortality in children under five years of age; lower the incidence or severity of infectious disease and nutritional disturbance cases; guarantee adequate quality of care in children under five years of age, in health services, at home and in the community; and strengthen health promotion and child preventive

actions<sup>(9)</sup>.

In Brazil, the *Programa de Saúde da Família* (PSF – Family Health Program), created in 1994 and instituted as a national primary care policy, has been found to be adequate for the establishment of the IMCI strategy<sup>(2,7)</sup>. The PSF seeks to focus on health care humanization by interacting with the population and by causing the team to be responsible for the resolution of community health problems. Welcoming in the PSF is considered to be a space where the user's health needs are attended to, thus promoting humanized care and better power of resolution, aiming at a user-centered health service reorganization<sup>(10-11)</sup>.

It is necessary that a family health unit meets unexpected demands and understands to what extent the population values extreme events, which are usually not included in the health team's agenda, so that a family health unit can become user-centered. The professional must see to user demands for immediate care, consultations, exams or procedures and, based on these, offer other care possibilities, founded on care promotion, prevention and continuity<sup>(11)</sup>.

Child caregivers will share children's reality, weaknesses and suffering with those professionals who show, in addition to their ability to listen, a clinical performance that meets the children's and family's needs. In this perspective, family health team members must provide clinical care to users continuously, enabling them to form bonds<sup>(12-15)</sup>.

The IMCI gathers the communication and clinical practice components in a strategy, providing child assessment and safe behavior. This aspect is key, especially when thinking about child visits that were not previously booked (random), when service based on IMCI aspects could contribute to care resolvability.

Thus, this study aims to describe the service performed by nursing professionals for children under five years of age in a family health unit, having in view a way to rethink health practices and the IMCI strategy contributions to basic child health care.

## METHODS

This investigation is a descriptive study and the location selected for it was a USF in the city of Ribeirão Preto, in the countryside of the state of São Paulo. Initially, in the research exploratory phase, researchers approached the health unit so that professionals could share the difficulties in their routine. Concomitantly, welcoming provided by this unit was identified, aiming at action proposals.

First of all, during the exploratory phase, there was a permanent education process with the unit's health professionals, using the IMCI strategy and welcoming as main contents, integrating theoretical and practical

activities. Debates and reflections on the theme of welcoming were conducted. In addition, the objectives, steps, clinical approach, guidance and communication process with the family, proposed by the IMCI strategy, were debated and understood.

During this joint work dynamics, researchers proposed to structure, with the professionals, the implementation of welcoming to children, based on the IMCI strategy, in that USF. They agreed that aspects of the IMCI strategy guidance and assessment should be incorporated in the welcoming. However, classification and treatment should not be incorporated into nursing alone, but rather performed with doctors, in the welcoming team's multiprofessional perspective.

After permanent education, the welcoming implementation process began, with its focus on the IMCI strategy. At this moment, this study's field work was performed, with data collected from participative observation conducted by guidelines, during July and August 2006. The guidelines were the basis to emphasize professionals' performance aspects in relation to each child/caregiver. Researchers observed if the act of listening and communication between the professional and the child caregiver were present, if the child was assessed, and what types of behavior were adopted, according to IMCI aspects. Questions observed that went beyond the guidelines' limits, as well as the researchers' impressions, were recorded in a field journal.

Individuals involved in data collection were the following: one nurse, two nursing assistants and 30 children under five years of age who sought non-pre-booked care in the USF. The nurse has practiced her profession for 11 years, is qualified in Public Health and also has a previous IMCI qualification. The nursing assistants and the nurse have been working in this USF since 2001, when it was established. All the 30 children were in the following age groups: five aged up to six months, five between older than six months and one year, five between older than one year and two years, six between older than two years and three years, five between older than three years and four years, and four between older than four years and five years. Children lived on the outskirts of the city, where there is a slum and the population is predominantly young.

Data analysis was based on information gathered during the observation of the service provided to children in the USF's reception area. These moments led to an amount of descriptive and narrative information that comprised the study records. According to the descriptive survey<sup>(16-17)</sup>, this study deals with the description and documentation of aspects of a situation as it occurred, bringing IMCI strategy contributions to the process of welcoming children under five years of age, in the perspective of primary health care.

Data from the observation of welcoming of children in the USF, recorded in the guidelines and field journal, were submitted to repeated readings. These aimed to grasp the specificities of welcoming provided to each child, according to items from the participative observation guidelines. Based on this analysis, data were organized and described around three themes: communication and attitudes that promote interaction; clinical assessment and anamnesis; and resolubility.

This study was approved by the Ribeirão Preto School of Medicine/Health Center Research Ethics Committee of the University of São Paulo. Participants in this study were informed about the nature of the study and its objectives, requesting their participation and consent, and guaranteeing their anonymity. Those who accepted to participate signed an Informed Consent Form.

## RESULTS

This study was based on the observation of cases seen by nursing professionals during welcoming, together with the team. It is worth emphasizing that nursing assistants, despite their IMCI qualification, welcomed the children studied under the nurse's supervision.

Even though welcoming users involves all the moments when professionals and users meet, this study was restricted to the observation of welcoming provided by nursing professionals in the USF reception area. However, researchers tried not to lose sight of each child's welcoming process triggered by the health team in the unit (medical consultation, types of behavior, treatments and referrals applied).

Aspects raised during the service, using the participative observation guidelines and field journal, are shown according to themes previously mentioned. However, it is worth emphasizing that, despite this categorization, the relationship among professional clinical abilities, communicative skills, resolubility, and user's interaction with the unit were taken into consideration.

### Communication and attitudes that promote interaction

In all cases nursing professionals showed initiative to serve. Visual contact was established, sometimes shyly at first. Then, they demonstrated growing interest in the complaint/problem, and listened attentively.

There was concern about sitting the child and the one accompanying it, even if there were many visits (18 cases) to the unit's reception area.

Even after researchers' interventions, one important strategy – verifying caregiver's understanding through

questions – was scarcely used.

Professionals' concern about the work process continuity was observed, establishing communication with other team members, such as case discussion with the doctor and referral for a medical consultation, with subsequent dialogue between the doctor and the nursing professional responsible for the visit, clarifying signs, symptoms, diagnostic hypotheses, and treatment. Moreover, communication with community health workers (CHW) was established to follow children who should receive special care and treatment at home and those counter-referred after being given a referral.

### Clinical assessment and anamnesis

In all cases, child weight and axillary temperature were measured. Respiratory frequency was observed in all children with complaints that required this type of measurement.

According to the complaint that brought the child to the unit, the following distribution was present: cough or breathing difficulty – 18 cases; fever – 15 cases; diarrhea – nine cases; ear problems – six cases; and others, such as eye secretion, burning, sore throat, toothache, vomiting, constipation, abdominal pain and anal irritation – 15 cases. It should be emphasized that 25 children showed more than one initial complaint and that, among children who had complaints that were not mentioned by the IMCI (15 children), 11 also had complaints mentioned by this strategy.

The following general danger signs, mentioned by the IMCI strategy, were analyzed in all children: the child is not able to drink or suckle, the child vomits everything it eats, the child has/had convulsions, and the child is lethargic or unconscious. Thus, three cases of children showing danger signs were detected: one child vomited all that it ate and two were lethargic.

Except for one case, caregivers were questioned about main symptoms present in children (cough or breathing difficulty, diarrhea, fever and ear problems). When one of these symptoms was present, the child was not assessed for related signs in two visits exclusively.

Considering what is proposed by the IMCI<sup>(2)</sup>, the 22 children with cough or breathing difficulty were assessed for this problem, and two were found to have rapid breathing, one had subcostal retraction and two had stridor or sibilance. Of the nine children with diarrhea, one had persistent diarrhea, another was lethargic and yet another was irritated, drank liquids offered avidly, had sunken eyes and its skin moved slowly back to its previous state after the skin-fold test was applied. None of the children with diarrhea was unconscious, unable to drink or drinking poorly, and none showed blood in their feces and very slow skin fold movement. Among the 15 children who had a fever,

none of them had a fever everyday for more than seven days, showed neck rigidity, petechiae or fontanel bulging. Of the seven children with ear problems, four complained about pain, three about secretion and none had a painful swelling behind the auricular pavilion. These seven children were sent to a doctor to have an otoscopy performed, of which one who complained about secretion only had ear wax.

Presence of palmar pallor was observed to check for anemia in all cases, when two cases of palmar pallor were detected and none of severe palmar pallor. However, as regards malnourishment, the only sign checked in all children was visible severe loss of weight.

Growth and development assessments, as well as maternal breastfeeding and diet, were performed in seven children who showed significant complaints. Only 15 children had their vaccination status checked, revealing that in 12 cases the professional asked about the vaccination status, but the caregiver did not bring the vaccination card.

Finally, questions about health care and habits were raised during welcoming in nine cases, when associated with the child's problem, such as: perianal hygiene for children with anal burning; diet and food and hand hygiene for children with diarrhea; habit of lying down to breastfeed children with ear problems and dental hygiene for children with a toothache.

### Resolubility

The team had the initiative to solve problems, quickly identifying priority and urgent situations.

After being welcomed by nursing professionals, 14 children required a medical consultation, and the remaining ones were discharged after assessment, case discussion with the doctor and guidance during welcoming.

As regards the treatment, nursing professionals and the doctor jointly adopted symptomatic treatments, with medication (such as antipyretics and analgesics) or not. In addition to symptomatic treatments, topical treatments were jointly prescribed, such as potassium permanganate baths and ointments. Other types of treatment, such as anthelmintics, antibiotics, and aerosol with bronchodilators, were prescribed by the doctor exclusively. A total of seven children received part of or the complete treatment in the service.

As recommended by the IMCI<sup>(2)</sup>, mothers and caregivers were provided guidance on the treatment (21 cases), adequate diet for the child's problem (7 cases), continuity of diet and offer of liquids to the child (20 cases), immediate return signs and symptoms (27 cases) and booked return date, when necessary (19 cases).

Another IMCI practice<sup>(2)</sup>, handing out information flyers to caregivers, which contributes to emphasize the

guidance, occurred in only one case, concerning food guidance.

A total of five children needed to be referred to the district's health unit and were helped by the team to obtain such referral. One of them showed high respiratory frequency, subcostal retraction and lethargy; another showed stridor and sibilance; one vomited all that it ate and was lethargic; one needed emergency dental treatment; and one needed to have its vaccination status updated.

Following the IMCI proposal<sup>(2)</sup> to take advantage of random demand to organize the health service, follow-up booking for each infant's well-child care was observed and its importance was mentioned, and those who had no follow-up were booked one when this opportunity arose.

## DISCUSSION

The health unit's reception area can be viewed as a space that allows adequate welcoming of users. One study that sought to describe welcoming performed in ten *USFs* emphasized the lack of privacy to receive these users, which could reduce its potential, as privacy would be one foundation for the desirable relationship of trust between users and professionals<sup>(18)</sup>. The environment's physical inadequacy was also pointed out as an unfavorable condition to experience welcoming by *PSF* professionals interviewed in a different study<sup>(19)</sup>.

In this study, it was observed that, when consulting rooms were available, visits were made in these preferably. However, all consulting rooms are often busy and waiting for rooms could mean missing opportunities for qualified listening and child assessment. This strategy prevented children who needed immediate care to wait for service with the other users, and it helped to solve problems for which medical care was not required. For this reason, the unit's reception area was adapted to these visits, whenever possible, moving furniture and keeping materials where they can be easily found.

Lack of verification of caregiver's understanding through questions shows that research subjects need to better understand the communication process with this caregiver. Similar situation was also pointed out by a study<sup>(7)</sup> that sought to define the contextual determinants of the IMCI strategy's implementation level in ten cities of the state of Pernambuco.

Communication between professionals and CHWs, as observed in this study, aimed to continue the work process. The importance of this issue was also emphasized by a pioneering study on IMCI strategy use by CHWs in home visits, in the cities of Recife and Olinda. In this study, post-consultation follow-up at home, performed by the CHW to provide guidance to

and supervise families when medication is administered, solved questions and contributed to increase treatment adherence<sup>(20)</sup>.

As regards questions about the four main symptoms, according to the IMCI, if the caregiver omits the presence of a symptom, the professional must not assess the child for signs associated with this symptom<sup>(2)</sup>. However, in the presence of such symptoms, the child must be assessed for related signs, something that did not occur in only two visits during the participative observation to collect data. By asking about the presence of the four main symptoms, problems other than the initial complaint can certainly be detected. Among research participants, the number of children with cough as the initial complaint, for example, was lower than the number of children who were assessed for cough, because this problem was identified as subject to assessment, despite its not being the initial complaint.

As regards the identification of malnourishment, checking for edema in both feet was considered in few cases, as were weight analysis and recording in the growth curve. Professionals reported that child weight is already supervised in the well-child care consultations. In addition, when children under two years of age miss booked consultations, CHWs perform home visits to, at least, measure child weight and vaccination status. Thus, there was consensus that growth and development assessment, as well as maternal breastfeeding and diet assessment, would only be performed during welcoming if there were serious complaints, which occurred in seven cases. It is relevant to mention that it was the nurse who assessed development in the cases where this was necessary.

Assessment of child food habits, according to the IMCI strategy, was identified as inadequate (35.4%) in an evaluative study on IMCI in the Brazilian Northeast region<sup>(21)</sup>. In this same study, even though child weight recorded on growth cards was significantly better in the IMCI-qualified professional team, yet this practice was not performed in all cases, reaching 77.3%.

Verification of vaccination status was hindered by the fact that several caregivers have not acquired the habit of taking the child's vaccination card when they go to the health unit. This issue was emphasized by professionals at each meeting, during welcoming. However, CHWs also assess vaccination cards of children under two years of age in their monthly home visits.

Child health care, as well as growth and development follow-up, child disease control, diet guidance and vaccination, are important aspects to promote good child health conditions, and the nurse has a key role in quality of care<sup>(22)</sup>.

The welcoming process with child assessment, team discussion and guidance was a valuable contribution to

the unit's work dynamics, because, before this experience, any child requiring random service would be sent to a medical consultation, without risk assessment. In this way, vacancies for random medical consultations would already run out in the beginning of the day, forcing children who arrived later to seek the emergency service of the district's unit, thus overcrowding it. Even if the child had to be submitted to a medical consultation after being welcomed, identification of needs by listening and valuing complaints would already have occurred, an aspect that promotes interaction, as mentioned by an essay on nursing work in primary care<sup>(23)</sup>.

This becomes especially important in child health, because extreme events cause child caregivers to feel anguish and anxiety and, when their complaints are not heard in the *USF*, to resign themselves to a repressed demand and end up being cared for in emergency services, seeking to satisfy their immediate needs and forcing the health system to be organized according to emergency services. In this way, primary care, aimed to be the health service system organizer, becomes only the system's entryway, i.e. a location with low resolubility in general, whose purpose is to simply receive users and refer them to the care levels, without interaction in the health service system<sup>(24)</sup>.

The fact that some children were treated in the service, in addition to guaranteeing the treatment is adequately provided, also served as demonstration for those accompanying the child. This practice consists in a strategy to counsel the mother or those accompanying it, which occurred with seven cases in this study exclusively. This practice is viewed as extremely important, and it could have been further used in the situations observed.

Even though conducting interviews had not been proposed by this study, in a way, users' and professionals' satisfaction with the strategy was identified. In the beginning of the participative observation, mothers or caregivers showed concern with the assessment performed by a professional other than a doctor and with the fact that the approach to welcoming also takes time if medical consultations were necessary. Subsequently, users began to realize the nursing professionals' ability to listen, dialogue, clinically assess and make decisions, and also understood that the process counts on the integration of the whole team, including doctors. Concomitantly, satisfaction of individuals was expressed both verbally and in the form of caregivers' requests for the welcoming team's assessment of their children on arrival, rather than the medical consultation specifically.

Nursing assistants also verbalized more trust and autonomy in their professional practice, with growing satisfaction as they felt capable of performing immediately when facing users' afflictions. Thus,

welcoming is a key resource for professionals and users to place themselves positively in the health care environment, enabling the population's effective requirements to regulate intervention proposals<sup>(25)</sup>.

Actions and findings of this study are in agreement with another study, where authors point to factors that influence the welcoming team's resolubility, such as constant debates, team qualification, interaction and use of protocols<sup>(10)</sup>. This study promoted permanent education, with debates and team qualification, who worked in an interactive way when welcoming children, based on the IMCI strategy, which proposes systematic care practices.

## CONCLUSIONS

In general, actions developed in this study contributed to the dynamics and resolubility of welcoming of children under five years of age, who required random service.

Nursing professionals showed higher performance when facing the complaints shown by children and pointed out by caregivers, thus creating self-trust and professional satisfaction. Users could have their complaints heard and assessed, even though there were no more vacancies for medical consultations on a certain day. Priority situations could be quickly identified, as well as other problems, in addition to the initial complaint raised and mentioned. Caregivers were given relevant guidance on child care, which was suitable for their reality.

Qualified listening practice, together with the professionals' clinical performance and team interaction identified by this study, are factors that can influence the way users interact with the unit, especially those who care for children under five years of age.

Some aspects, associated with child assessment, case management and communication with caregiver, need to be overcome in the short term. Others, however, such as physical space inadequacy and little interaction among sectors, are related to the service structure and dynamics and go beyond the sphere of this study.

Findings from this investigation show reproductive potentiality in other *USFs*. To achieve this, it is important to create a reserved and equipped space for welcoming, with a table, chairs, service formularies, printed materials showing IMCI strategy diagrams, thermometer, physiological solution to be administered intranasally, oral rehydration solution, child stethoscope, stretcher, scale and posters with health information. Furthermore, permanent education is a way to improve and maintain welcoming, despite work routine's obstacles.

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