

Child Health Surveillance: nurses perspective

Vigilância em Saúde da Criança: perspectiva de enfermeiros

Vigilancia en Salud Infantil: perspectiva de enfermeros

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ABSTRACT

Objective: to analyze conceptions of nurses on child health surveillance in family health units. **Method:** a qualitative study with thematic analysis of the data, based on the paradigm of Health Surveillance. Interviews were conducted with 13 nurses in a countryside city in the state of Sao Paulo. **Results:** nurses conceived child health surveillance as an active monitoring, which should be comprehensive, identifying risks/vulnerabilities, through multidisciplinary and intersectoral actions that are dependent on maternal involvement. We found partial development of these assumptions in practice, due to difficulties such as lack of maternal involvement in the proposed actions, lack of time for discussion and adoption of measures in the units and disarticulation between levels and sectors of the city. **Conclusion:** a greater political and technical investment is needed to ensure the adoption of this model in different sectors and levels of care of the city.

Key words: Surveillance; Children's Health; Family Health Strategy; Nursing.

RESUMO

Objetivo: analisar concepções de enfermeiros sobre Vigilância em Saúde da Criança (VSC) em unidades de saúde da família. **Método:** estudo qualitativo, com análise temática dos dados, fundamentada no paradigma da Vigilância em Saúde. Foram realizadas entrevistas com 13 enfermeiros atuantes em município do interior paulista. **Resultados:** os enfermeiros conceberam VSC como acompanhamento ativo, integral, programado, identificando riscos/vulnerabilidades, por meio de ações multiprofissionais, intersetoriais e dependentes da participação materna. Constatou-se desenvolvimento parcial dessas premissas na prática, por dificuldades como falta de participação materna nas ações propostas, indisponibilidade de tempo para discussão e adoção de medidas nas unidades e desarticulação entre níveis e setores no município. **Conclusão:** é necessário maior investimento político e técnico para assegurar a adoção desse modelo nos diferentes setores e níveis de atenção do município.

Descritores: Vigilância; Saúde da Criança; Estratégia Saúde da Família; Enfermagem.

RESUMEN

Objetivo: analizar las concepciones de los enfermeros en la vigilancia de la salud de los niños en las unidades de salud de la familia. **Método:** estudio cualitativo con el análisis temático de los datos, basado en el paradigma de la Vigilancia de la Salud. Se realizaron entrevistas con 13 enfermeras en la ciudad interior. **Resultados:** las enfermeras concibió la vigilancia de la salud del niño y la vigilancia activa, total, la identificación de riesgos/vulnerabilidades, a través de acciones multidisciplinario, intersectorial y dependiente de la participación materna. Encontramos lo desarrollo parcial de estos supuestos en la práctica, debido a las dificultades, como la falta de participación de la madre en las acciones propuestas, la falta de tiempo para el debate y la adopción

de medidas en las unidades y la falta de conexión entre los niveles y sectores en el condado. **Conclusión:** es necesaria una mayor inversión política y técnica para asegurar la adopción de este modelo en diferentes sectores y niveles de atención del municipio. **Palabras clave:** Vigilancia de la Salud; Salud del Niño; Estrategia de Salud Familiar; Enfermería.

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INTRODUCTION

The implementation of new technological resources in the health care of children generated an improvement in survival rates of this population group, however, global infant morbidity rates are still worrying⁽¹⁾.

Similarly, for the last three decades, advances in Brazilian health services have been observed, as well as changes in the determinants of disease, especially social determinants, pointing to the improvement of the latter. However, in Brazil, the adverse conditions in which children from economically disadvantaged families live are still challenging, highlighting that it is essential to understand the nature of the problems and the establishment of interventions that can reduce inequalities⁽²⁻³⁾.

Thus, as a proposal to change this situation, the Brazilian Ministry of Health (MH) recommends the adoption of the Child Health Surveillance (CHS), highlighting it as a strategy in the proposed guidelines for the purpose of reducing mortality rates and increasing access for quality of care of health services for children and their families⁽⁴⁾.

Health Surveillance has been defined as the active role of professionals and health services in the face of risk and vulnerable situations, mapping and planning specific actions to minimize the damage and carrying out the appropriate monitoring of population's health⁽⁴⁾.

Currently, it can be considered that this strategy is configured as alternative care model (technological mode of intervention) intended to overcome the dichotomy between collective practices (epidemiological and health surveillance) and individual (outpatient and hospital care), considering the ways of life of different social groups, based on epidemiology and contributions from other areas as of knowledge such as geography, urban planning, strategic management and social sciences in health, with the political and institutional support, the process of decentralization and reorganization of services and health practices at a local level⁽⁵⁾.

Its main features are: actions on the territory; interventions facing health problems in the various health and disease stages; highlights on the problems that require attention and continuous monitoring; approaches to risk assessment; articulation between promotion, preventive and curative actions; intersectoral action and intervention in the form of operations⁽⁵⁻⁷⁾. It is noteworthy that, in the context of health promotion, the mentioned model calls for the development of actions that anticipate the damage or aggravation, recommending interventions

to adopt the expanded concept of health care, such as promoting quality of life^(5, 8).

In the Primary Health Care (PHC) in Brazil, the health surveillance model began to stand out during the process of reorganization of the Brazilian Unified Health System (SUS) to be incorporated into the care model of the Family Health Strategy (FHS). This strategy, for instance, seeks the integrality of care for individuals and families over time and resolving answers to populations and community needs⁽⁹⁾.

It is recognized that PHC nurses responsibilities include the performance of administrative and care actions of CHS⁽¹⁰⁻¹¹⁾. However, reflecting on this aspect, it is important to know how these professionals develop such actions in their daily practice in the family health units (FHU), in order to analyze their professional contribution to integrality of children health care.

OBJECTIVE

The aim of this study was to analyze conceptions of nurses regarding Child Health Surveillance, relating to their experience in the Family Health Strategy.

METHOD

A qualitative study approach, based on the conceptual principles of health surveillance in the context of PHC in relation to promoting health of children and their families and the strengthening of knowledge and shared practices⁽⁹⁾.

The qualitative method applies to investigations that focus on relationships, beliefs, perceptions and opinions of the subjects, deepening the world of meanings attributed by them to the lived reality, admitting the importance of their perspective in shaping this reality⁽¹²⁾.

The field of research was carried out in an agro industrial medium-sized city in the countryside of the state of Sao Paulo, whose children health indicators pointed to the need for improvement of the attention provided to perinatal health care and early years of a child's life. In 2012, the perinatal mortality rate was 15.24 per thousand live or dead births, and in this same year, the infant mortality rate in the city was 8.88 deaths per thousand live births and neonatal mortality of 5.92 deaths per thousand live births⁽¹³⁾.

The study included all 13 nurses who were working at the FHS of the city during the study period, covering all the Family Health Units (FHU).

Data collection was performed during the period from June to July of 2011, through semi-structured interviews, with the following guiding questions: - What do you understand by Health Surveillance? - Describe your job at the FHU regarding the CHS. Additional questions to nurses were asked to clarify the statements issued during interviews. For characterization of the participants, information was obtained on gender, age, place and time of training, work and courses taken after graduation related to public and child health. The interviews were scheduled in advance by the interviewer with FHU nurses, recorded in MP3, transcribed and deleted after the transcripts.

To analyze data, we used the content analysis method, creating Thematic categories, covering three stages: pre-analysis, material exploration and treatment of results, inference and interpretation⁽¹²⁾. For the first stage, a careful reading of the selected material was performed, seeking to have an overview focusing on peculiarities. Modes of original classification were also selected and defined from the guiding concepts of analysis. In the second stage, the distribution of quotation and sentences from the initial classification was conducted, with regrouping of the quotations by themes and units of meaning, linking them to the concepts that guided our analysis. For the third stage, we developed the interpretative summary to relate the themes with the objectives and assumptions of the research⁽¹²⁾.

The study was approved by the Research Ethics Committee of Botucatu Medical School, Universidade Estadual Paulista (REC Protocol 3803/2011). Each research participant signed the two copies of the Consent Forms.

RESULTS

Out of the 13 nurses interviewed, 12 were female. The age ranged from 23 to 41 years old and they had graduated between 1995 and 2008. In the FHS, all of them worked in management and assistance to registered families. Working time at the FHU varied between one month and two and a half years. Regarding coursed activities after graduation short courses on Child's Health and longer courses in Family's Health and Public Health were cited.

The reports on the views and experiences regarding the CHS under the FHS are presented below, grouped into themes, containing the units of meaning that emerged from the statements, identified with a number of nurse (N1 to N13).

Health Surveillance as a strategy for integrality of child health care

Participants identified the CHS as active, integral and constant monitoring of the child.

I think we should work on the top of what we have as principles of SUS and also as principles of Family's Health. Then, thinking about the guidelines, even for actions like promotion, protection and health recovery. We are supposed to pay close attention to the child and to those who live with the child. So, when we think of a child's health, we have to think about the health of the child and not only in a binomial manner which is the mother and the child,

but often we have to see the whole context where this child is inserted. And when, in fact, we can care for the family health. (N7)

In family health, we do not expect people to come to us. We have to do an active search. So in Child health Surveillance, we do this active search, we make an appointment, if the child doesn't come we ask, "But why didn't she/he come?" So we have to reschedule! It provides both individual and group care, all thinking about the child's well-being, the best way to guide this mother, this father. (N4)

In the process of Health Surveillance, SUS principles are emphasized at the interface with the FHS, and health promotion actions are also highlighted, protection and recovery need to be organized and offered in an inseparable way to the achievement of the integrality of child's health. At the same time, was found in the statements their ability to identify problems and prioritize treatment, so there is a special care.

When providing prenatal care, the pregnant woman care should be evaluated as a low risk prenatal care or a high risk prenatal care, if there are any complications. When the baby is born, a nurse should make home visits. So, in this period, the nurse is supposed to see the house, the environment, family, family conditions, conditions that the mother is going through. (N10)

I think we should have a very broad view of the service we provide for the Health Surveillance care. You will know if this family is at risk if you need to visit them more often, if you need to call them more to come to the unit. (N11)

The model was related to a careful and closeness process with families, beginning from the prenatal period, focusing on priorities that are regarded according to the levels of risk to the child, mother or family, especially considering the social context in which they live. However, narrower conceptions were identified only one dimension of Health Surveillance, namely the Epidemiological Surveillance, mentioning only aspects such as identifying the epidemiological profile and reporting communicable diseases.

I understand that children have diseases that are transmitted, specially the ones which should be notified in order to do a good block. Diarrhea, measles, chickenpox. Child Health Surveillance is to see what is important, in order to perform the notification of cases so that we can take control measures. And, I think especially those with transmissibility, children attending school or who live at home, or parent with tuberculosis, we do a screening to control and block the disease. To break the chain. (N9)

Child Health Surveillance as a cross-sectional action of the Family Health Strategy

According to participants, CHS is developed at the FHS and is recognized in different actions and moments of care. In order to be performed in a satisfying manner, there must be planning, organization of care, closeness and constant contact with families.

We do surveillance, focusing on what we call "programmatic" in scheduled. (N7)

So at the health unit, we have individual care that I share with the doctor. We care for the child since he or she is born. By the seventh day, we go to their houses to guide them, especially regarding breastfeeding and baby care. In fact, I think that care for the child begins even earlier, in the pregnant group [...] We alternate, between medical and nursing consultation. [...] We have groups with children from zero to two years and another group that is from two to five years, mainly focused to mothers who haven't been bringing their children into the routine. That's pretty cool! (N8)

Therefore, according to the nurses, the CHS within the FHS has involved the chain of care and individual and group actions, giving importance to the effective participation of parents. As to the latter, identified a number of barriers to the realization of the model, with difficulties for health surveillance of the child regularly and taking into account actions proposed by FHU:

Now, our greatest difficulty is the lack of scheduled patients. Because then the kids will only come if mothers bring them along. And here in the neighborhood, they are very sincere. For example, the cleaners, they could be suddenly called to clean a house on that day, so they don't bring their children. Then maybe there is a bit of lack of appreciation of the scheduled appointment. The child arrives at the unit with the disease, and, then, we cannot even make prevention. (N3)

The work of different professionals for the CHS has proved to be one of the facilities at the FHS, with child monitoring by dentists, physicians, nurses, community health agents (CHAs), among others. However, there is lack of professionals and difficulties of availability of time.

Well, as an unit in the Family Health Strategy, all programmatic patients, especially children, are attended by the doctor, nurses and other professionals, such as oral health professionals, nutritionists, there is also the community health agent, to build and expand the bond with these families so that these children are always monitored. So, it is different from a traditional basic unit. (N1)

The biggest difficulties we face are related to the service, we don't have enough time and manpower to do activities of health promotion. We end up being drowned by demand, there's no way to take a person of care to go to promotion activities in the community, at school. (N5)

Participants recognized that the actions aimed at children have enabled the Health Surveillance to focus on constant monitoring of child growth and development by different health professionals. However, this monitoring is not always the case with teamwork and organized to cover health promotion activities in the community. The statements also show that on a daily basis, they have been attending the emergency demands of users, sometimes to the detriment of scheduled service.

For the viability of CHS actions in order to integrality of care, nurses also stressed the importance of partnership with other levels of health care and social facilities such as nursery and schools. However, they also pointed out difficulties due to lack of planning, organization and evaluation with regard to the proposition and implementation of intersectoral activities.

In the comprehensive evaluation of the child, surveillance begins from birth, in the maternity. (N1)

We have a lot of partners, with the nursery, with the school, with social workers, district leaders. (N2)

I think the biggest difficulty is for us to sit, to stop, to plan [activities], because our routine as a nurse of a family health unit is too heavy. But if we stop and think a bit harder for a moment ... I think every day we end up developing an action, however, without realizing it ... I think it's not very structured, planned. I think the difficulty is the lack of planning, evaluation and organization. (N6)

DISCUSSION

Conceptions learned in this study about CHS proved to be expanded and in line with government premises assigned to this model^(4,8), as well as the major characteristics indicated by the related topic on the scientific literature⁽⁵⁻⁷⁾. They appear to be permeated by the paradigms of public health, approaching the clinic model. Thus, nurses identified the CHS with monitoring through monitoring of growth and development of programmed care educational actions; developed by multidisciplinary teams, with the possibility of early identification of problems, according to individual, family risks and the socio-economic and cultural context, and propose promotion, preventive and curative actions at different levels of health care and sectors of society.

Officially, it is postulated that Health Surveillance actions should include the promotion of health, carried out in daily family health teams, with roles and responsibilities defined in one area of activity, integrating work processes, planning, monitoring and evaluating these actions⁽⁵⁾. In agreement with this, as reported by nurses, one of the principles on which the Health Surveillance is based is territorial, with the mapping problems, knowledge of the territory, social groups that compose it, the socioeconomic and cultural context, understanding and knowing the environment⁽⁸⁾, in this case, where the child is inserted.

It should be noted, however, the low appreciation of the active participation of users in the process, which deserves to be constantly revised so that progress is made in sharing actions and responsibilities for the care, critical to the advancement of the model⁽⁴⁾. Furthermore, although conceived as a result of the implementation of the CHS model, the reorganization of the work process of health teams, aimed at solving the problems, was not clearly stated⁽⁵⁾. The health surveillance model has on its policies the proposed restructuring of care to the health-disease process, in which health problems are analyzed so that the different segments may face it in an

integrative way, looking at the child, the family and the community as subjects of this process⁽⁴⁾.

Another point worth mentioning is that between the conceptions of nurses emerged, there were some limitations to the conceptual aspects of traditional Epidemiological Surveillance, taking communicable diseases as object⁽⁵⁾. Although the epidemiological approach has historically been adopted in Brazilian child health programs⁽¹⁴⁾, it is recognized that this framework limits the possibilities of Health Surveillance in identifying the disease and its control⁽⁵⁾, moving away from the perspective of integrality of care in child health.

These features suggest that the reason some nurses relate their concepts of CHS to the Epidemiological Surveillance can be connected to the training of these professionals, the short time of experience at the FHS and the few opportunities for Continuing Healthcare Education (CHE).

Studies^(11,15) have pointed out that professionals working at the PHC have deficiency of knowledge about the CHS in general and especially as regards the monitoring of Child's growth and development, increasingly the necessity for training of professionals to the practice. Therefore, there is great importance in triggering CHE processes in FHUs, focused on the theme of Health Surveillance.

The practical experience of nurses on the CHS in daily FHU are predominantly related to the individual care appointments, to some extent, has allowed the identification and disease prevention, monitoring and health promotion. Consistent with the reported experiences, it is expected that in the FHU the CHS held by health teams approach the child growth and development process, which should be initiated in the prenatal period, with continuity after the child's birth. It should also be linked to other levels of health and social facilities, through promotion, prevention and child health recovery⁽⁴⁾.

In the monitoring of growth and development care line, the family health team should: encourage families for routine follow ups; knowing the child population in the surrounding areas of the health unit to perform actions according to their health needs; conducting active search for children in need; maintaining the practice of listening to children and families, assessing risk signs and the child card, guiding the family about the importance of its use^(4,16).

For professional nursing practice, in line with the implementation of the FHS, the adoption of different aspects of the characteristic of the traditional model of health care, centered on curative actions has been recommended⁽⁹⁾. Thus, from the moment the nurse belongs to the field of FHS, the incorporation of specific concepts to improve their work process is necessary, qualifying the actions and organizing teamwork, with the use of technological tools in order to reconcile it with the specific knowledge⁽¹⁷⁾, such as those related to the Health Surveillance.

At the same time, the adoption of FHS care model has expanded the possibilities for nurses to perform clinical care more often⁽¹⁸⁾, sharing with physicians well-being actions for the child. These actions are essential to enable integrality and longitudinally child health care. Among them are: visits and consultations to priority groups, community meetings,

educational groups, home visits and others. Child primary care must be performed to development and monitoring of child growth, enabling the promotion of the bond between the family and the health unit^(4,16), as pointed out by participants.

Thus, nurses recognize that in their work process, they have been able to implement some premises of CHS, to perform scheduled service in individual consultations and working with educational groups, sometimes giving priority to care for children at risk or who are vulnerable.

Along with several positive aspects reported by the nurses in relation to contributions to the CHS in the FHS were pointed out others that have hindered the development of actions.

In the middle of the reorganization of the care model adopted by the FHS, within the mentioned difficulties, the highlights are: those relating to the political priority given to emergency care and complaints from users on a daily basis, which greatly occupy nurses to meet these demands, the accumulation of care and administrative activities added with the lack of professionals to compose teams. As a result, one of the key actions for the development of the CHS is not happening: the establishment of moments and spaces for reflection and evaluation of the health-disease process of children attended by the FHU, with concurrent planning and propose actions to qualify the care provided to the individual, family and population.

Another challenge pointed to overcome was the distancing of parents for monitoring children's health, identified when there is a lack of children and their responsible to scheduled activities. As proposed for approximation of families of children to health units, participants pointed to educational activities that value the importance of active partnership between parents and professionals as it can be performed individually or in groups, both in health units and outside them.

Participants confirmed that the shared work favors the CHS, leading to the increase of actions and expanding care. However, according to the interviewees, this has not happened consistently, requiring the adoption of instruments and evaluation processes, planning and organizing care, both internally and externally to FHU in search of the integrality of care to Child's health.

A reflective study⁽¹⁹⁾ on the technical success of concepts, practical success and practical knowledge, and the importance of coordination of these to broaden the understanding of child nursing care highlighted the priority to look at daily life in a practical way and not only technical in order to deal with the procedural nature of health care, which does not occur naturally, it is complex and should be systematically rebuilt.

This study refers to nurses' perspective on CHS and its practical application in the context of FHS of a local and specific reality. It is believed, however, that these results can significantly contribute to reflections and future actions in this and other realities that seek to enable the integrality and effective care of child health.

FINAL CONSIDERATIONS

Nurses conceived the expanded and coherent way of CHS with the official assumptions and current scientific literature.

We highlighted the active monitoring, integrality, scheduled throughout the growth and development process, identifying problems presented by children or which they may be exposed to in the context where they live, through multidisciplinary and intersectoral actions, which are dependent on family participation. However, there was limited references to the concept of Epidemiological Surveillance, and the potential of health surveillance contributions was not made explicit to the reorganization of practices aimed at the child population. In the development of this model in practice, difficulties have been identified, highlighting the lack of active participation of users in the actions proposed by the FHU, the unavailability for further discussions on issues of CHS in the FHU and the disarticulation between levels and sectors involved with actions related to childhood in the city.

It is considered therefore that the composition with the work of other members of health teams, nurses' practices with children and their families in the context of FHU, at certain times and situations, proved to be mediated by the Health Surveillance model, with a view to integrality of care to child's

health. At the same time, aspects that do not favor the adoption of the assumptions of this model were revealed, ultimately linked to the lack of proposition and city policies which may support the configuration of spaces for reflection, discussion and definition of the interventions (sectoral and intersectoral) with participatory and inclusive character among users, as appropriate, and professional assistance and management, in turn, properly prepared for this purpose.

The quality of care notoriously implies continuity of care and the Health Surveillance can provide relevant health information to the search for an expanded approach to integrality of care in the demands identified by nurses. It is important to enhance the communication between professionals and services, and build working prospects to avoid gaps and extend the integrality and intersectoral of network actions.

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REFERENCES

1. United Nations Children's Fund (US). The State of the World's Children 2012: children in an Urban World [Internet]. New York (US): UNICEF; 2012 [cited 2014 Nov 05]. Available from: http://www.unicef.org/sowc2012/pdfs/SOWC-2012-Main-Report_EN_21Dec2011.pdf
2. Barros FC, Victora CG, Scherpbier R, Gwatkin D. Socio-economic inequities in the health and nutrition of children in low/middle income countries. *Rev Saude Publica* [Internet]. 2010 [cited 2014 Nov 05];44(1):1-16. Available from: <http://www.scielo.br/pdf/rsp/v44n1/01.pdf>
3. Victora CG, Aquino EML, Leal MC; Monteiro CA, Barros FC, Szwarwald CL. Maternal and child health in Brazil: progress and challenges. *Lancet* [Internet]. 2011 [cited 2014 Nov 05]; 377(9780):1863-76. Available from: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(11\)60138-4.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(11)60138-4.pdf)
4. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Agenda de compromissos para a saúde integral da criança e redução de mortalidade infantil. Brasília (DF): Ministério da Saúde; 2005.
5. Silva GAP, Vieira da Silva LM. Health surveillance: proposal for a tool to evaluate technological arrangements in local health systems. *Cad Saude Publica* [Internet]. 2008 [cited 2014 Nov 05];24(11):2463-75. Available from: <http://www.scielo.br/pdf/csp/v24n11/02.pdf>
6. Faria LS, Bertolozzi MR. The surveillance in health basic: perspectives to reach the surveillance in health. *Rev Esc Enferm USP* [Internet]. 2010 [cited 2014 Nov 05];44(3):789-95. Available from: http://www.scielo.br/pdf/reeusp/v44n3/en_34.pdf
7. Arreaza ALV, Moraes JC. [Health surveillance: foundations, interfaces and tendencies]. *Cienc Saude Colet* [Internet]. 2010 [cited 2014 Nov 05];15(4):2215-28. Available from: <http://www.scielo.br/pdf/csc/v15n4/a36v15n4.pdf> Portuguese.
8. Ministério da Saúde (BR), Secretaria de Vigilância à Saúde, Secretaria de Atenção à Saúde. Diretrizes Nacionais da Vigilância em saúde. Brasília (DF): Ministério da Saúde; 2010.
9. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília (DF): Ministério da Saúde; 2012.
10. Silva VG, Motta MCS, Zeitoun RCG. [The nurse's practice in the family health strategy: the city council of Vitória/ES case]. *Rev Eletrônica Enferm* [Internet]. 2010 [cited 2012 Jan 13];12(3):441-8. Available from: http://www.fen.ufg.br/fen_revista/v12/n3/v12n3a04.htm Portuguese.
11. Reichert APS, Almeida AB, Souza LC, Silva MEA, Collet N. [Surveillance to infant growth: knowledge and practice of nurse's primary health care]. *Rev RENE* [Internet]. 2012 [updated 2015 Mar 30; cited 2012 Jan 13];13(1):114-26. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/23/19> Portuguese.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12. ed. São Paulo: Hucitec; 2010.
13. Seade.gov.br [Internet]. São Paulo: Secretaria de Planejamento e Desenvolvimento Regional; [sem data] [cited 2015 Mar 11]. Available from: <http://produtos.seade.gov.br/produtos/perfil/perfilMunEstado.php>
14. Figueiredo GLA, Mello DF. Child health care in Brazil: aspects of program vulnerability and human rights. *Rev Lat Am Enfermagem* [Internet]. 2007 [cited 2012 Jan 13];15(6):1171-6. Available from: <http://www.scielo.br/pdf/rlae/v15n6/17.pdf>
15. Reichert APS, Vasconcelos MGL, Eickmann SH, Lima MC. Assessment of the implementation of an educational

- intervention on child developmental surveillance with nurses. *Rev Esc Enferm USP* [Internet]. 2012 [cited 2012 Jan 13];46(5):1049-56. Available from: http://www.scielo.br/pdf/reeusp/v46n5/en_03.pdf
16. Mello DF, Furtado MCC, Fonseca LMM, Pina JC. [Child health follow-up and the longitudinality of caring]. *Rev Bras Enferm* [Internet]. 2012 [cited 2012 Jan 13];65(4):675-9. Available from: <http://www.scielo.br/pdf/reben/v65n4/a18v65n4.pdf> Portuguese.
 17. Costa RKS, Miranda FAN. [The nurse and family health strategy: contribution for assistencial model change]. *Rev RENE* [Internet]. 2008 [cited 2012 Jan 13];9(2):120-8. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/570/pdf> Portuguese.
 18. Matumoto S, Fortuna CMF, Kawata LS, Mishima SM, Pereira MJB. Nurses' clinical practice in primary care: a process under construction. *Rev Lat Am Enfermagem* [Internet]. 2011 [cited 2012 Jan 13];19(1):123-30. Available from: <http://www.scielo.br/pdf/rlae/v19n1/17.pdf>
 19. Mello DF, Lima RAG. Technical attainment, practical success and practical knowledge: hermeneutical bases for child nursing care. *Rev Lat Am Enfermagem* [Internet]. 2009 [cited 2012 Jan 13];17(4):580-5. Available from: <http://www.scielo.br/pdf/rlae/v17n4/22.pdf>
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