

## Qualification of the Childcare Approach: an Intervention in the Family Health Strategy Service

Qualificação do Cuidado a Puericultura: uma Intervenção em Serviço na Estratégia de Saúde da Família

Calificación del Cuidado de los Niños: Intervención en Servicio en la Estrategia Salud de la Familia

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### ABSTRACT

**Objective:** This paper aims to describe the experience report of an intervention used to qualify the childcare provided by a Family Health Strategy service in the municipality of *Boa Vista*, *Roraima* State, Brazil. **Methods:** The intervention involved the entire team and lasted 16 weeks, over the period from March to July 2015, in which actions were performed for the organization and management of the service, monitoring and evaluation, qualification of clinical practice and public engagement. **Results:** The actions allowed to qualify the care to 411 children, obtaining 98.6% of care coverage, as well as the qualification of the clinical practice, compliance with the actions with 100% of nutritional status monitoring and psychomotor development, and the intensification of activities for health promotion. **Conclusion:** The experience contributed to improve the service organization and team integration, then achieving an effective coverage and quality of childcare.

**Descriptors:** Family Health, Primary Health Care, Child Care, Child Health.

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## RESUMO

**Objetivo:** O estudo apresenta o relato de experiência de uma intervenção que teve como objetivo qualificar a puericultura em uma Estratégia de Saúde da Família no município de Boa Vista/Roraima. **Método:** A intervenção envolveu toda a equipe e teve a duração de 16 semanas, entre março a julho de 2015, nos quais foram instituídas ações direcionadas à organização e gestão do serviço, ao monitoramento e avaliação, à qualificação da prática clínica e ao engajamento público. **Resultados:** As ações permitiram qualificar o cuidado a 411 crianças, obtendo-se 98,6% da cobertura de atendimento, assim como a qualificação da prática clínica, adesão às ações com 100% de monitoramento do estado nutricional e desenvolvimento psicomotor, além da ampliação das atividades de promoção da saúde. **Conclusão:** A experiência contribuiu para melhorar a organização do serviço e integração da equipe alcançando resultados efetivos de cobertura e de qualidade da atenção relacionados a assistência a criança.

**Descritores:** Saúde da Família, Atenção Primária à Saúde, Puericultura, Saúde da Criança.

## RESUMEN

**Objetivo:** El estudio presenta la experiencia de una intervención dirigida a calificar para el cuidado de niños en una Estrategia de Salud Familiar en la ciudad de Boa Vista / Roraima. **Métodos:** El programa constaba de todo el equipo y duró 16 semanas, de marzo a julio de 2015, en la que fueron instituidas las acciones destinadas a la organización y gestión del servicio, seguimiento y evaluación, calificación de la práctica clínica y el compromiso público. **Resultados:** Las acciones permitidas calificar la atención a 411 niños, obteniendo el 98,6% de la cobertura del servicio, así como la calificación de la práctica clínica, la adhesión de las acciones con 100% de seguimiento del estado nutricional y el desarrollo psicomotor, además de la expansión de las actividades promoción de la salud. **Conclusión:** La experiencia ayudó a mejorar la organización de servicio y la integración del equipo logro de resultados efectivos de la cobertura y calidad de la atención relacionada con el cuidado de niños.

**Descriptor:** Salud de la Familia, Atención Primaria de Salud, Cuidado del Niño, Salud del Niño.

## INTRODUCTION

Childhood is a period in which much of the human potential develops. Nevertheless, the disturbances that affect it are also responsible for serious consequences for individuals and communities. There are many development changes that can affect a child since his birth, such as his psychomotor development, and even congenital diseases that can be discovered through professional evaluation and treated.<sup>1</sup>

Childcare is fundamental for a healthy development, with the Family Health Strategy (FHS) being one of the main Brazilian policies that develop this care. The FHS has been consolidated as one of the structuring axes of the Sistema Único de Saúde (SUS) [Unified Health System] by means of an expressive expansion of the population coverage and access of the population to health care actions. These teams work with the objective of guaranteeing the integrality of the assistance through the articulation among actions to promote health, prevention of diseases, health surveillance,

treatment and rehabilitation.<sup>2</sup>

One of the instruments used by the FHS to monitor the children's health is the childcare, understood as a moment of particular care in which the evaluation of the child occurs, the monitoring of growth and neuro-psychomotor development, the guarantee of vaccination coverage, stimulation to the practice of breastfeeding, guidance on the introduction of complementary feeding and prevention of the diseases that most frequently affect children in the first year of life, such as diarrhea and respiratory infections.<sup>3</sup>

In addition to the child's evaluation, the childcare aims to monitor the relationship between mother and child including the familiar social environment, identifying vulnerabilities, promoting access to necessary behaviors, health education, exchange of experiences, and formation of a partnership with the mother for the protective care of the child that promotes health and quality of life for children.<sup>4,5</sup>

Hence, the complexity of the childcare actions requires that the team be prepared not only to meet the clinical demands, but also to have an epidemiological and social conception capable of contemplating the individual, the family, and community from a posture of reception and dialogue. This action is an important challenge that requires planning by the team, organization and preparation for the development of childcare actions.<sup>6</sup>

Considering the importance of the team's work in the child health care of the FHS, this study aims to describe and analyze the experience of developing an intervention for the qualification of the childcare provide by a FHS service in the municipality of *Boa Vista, Roraima State, Brazil*.

## METHODS

The intervention project was developed during the activities of the Specialization Course in Family Health of the *Universidade Aberta do Sistema Único de Saúde (UNA-SUS)* in the *Universidade Federal de Pelotas (UFPEL)*. The management of the intervention project was carried out by a Cuban physician linked to the *Mais Médicos* ["More Physicians"] Program and involved the participation of the entire FHS team, one physician, one nurse, eight community health agents, one nursing technician, and the population of the covered area.

The logistics for the development of the intervention included the training of clinical practice for two weeks through meetings, workshops and joint training of all team's professionals, especially regarding the use of protocols and Basic Child Health Notebooks. Some ideas were discussed for this implementation: the attributions of each team member, disclosure of actions and schedules, scheduling of care and active search of absent people, vaccine schedule, psychomotor development of children, growth and development evaluation, accident prevention in the home, importance of breastfeeding, and caries prevention. The

training was carried out before and during the intervention. Once a week, in a team meeting, the monitoring and follow-up worksheets were presented and the results obtained were discussed. These Microsoft Excel worksheets were made available by the coordination of the specialization course.

The Basic Health Unit (BHU), which is the scene of the intervention project, was located in the urban area of Boa Vista city, Roraima State, Brazil, and had two FHS teams at that time covering approximately 14,000 users. The team in which the intervention was carried out served 4,117 users, mostly young people aged 20-39 years old. The living conditions of the families were precarious, most of them having low financial resources and very poor home conditions. There were many small houses with large families of up to eight people per habitation, with poor hygiene, little air circulation, no piped water, and no basic sanitation services. The main sources of income were self-employment and agriculture. On rainy days, many people were prevented from accessing certain areas of the neighborhood, including the health unit.

The physical structure of the BHU was small and precarious and did not have the necessary conditions for a warm and comfortable attention. There was room for the vaccines, screening, nursing and doctor's office, but there was no bathroom for the employees, nor a meeting room, dressing room, dental office, and room for nebulization and sterilization of materials. Furthermore, the BHU was located far from the residents of the covered areas, which certainly made its access difficult.

The situational analysis, foreseen at the beginning of the course, was an important pedagogical resource used by the team and also a powerful motivating tool for changes, since it promoted the team's knowledge about what was done in the FHS, about how the protocols provided by the Health Ministry should be used, and a self-analysis about its work process, in which it was possible to identify the limits and potential of the team and the users' needs. This strategy was fundamental to prioritize the problems and needs, also functioning as a trigger to qualify the actions.

The results obtained from the situational analysis led the team to develop the intervention in a contextualized way, with the objective of qualifying the health care for children from zero to 72 months of age and the team's work. It was identified that health care coverage for children was very low, with approximately 16 to 20 children being treated per month. Of the 417 children from zero to 72 months residing in the coverage area, only 10.54% were being followed up.

The childcare program faced many difficulties of coverage and qualification of its actions. Besides, the compliance with the childcare was not adequate, since it was not promoted by the team. The service worked precariously, not respecting the various steps and actions required, and the only services provided to the children were vaccination, verification of weight for the follow-up of the *Bolsa Família* [Family

Allowance] Program, and medical consultation when any problem was identified by the parents. The team was not aware of the need for systematic and ongoing monitoring of children.

The actions developed during the intervention encompassed four thematic axes: three from the public health area (monitoring and evaluation, organization and management of the service and public engagement) and one from the clinical area (qualification of the clinical practice). Actions were developed aiming the coverage expansion of the Child Health Program; improvement of the quality of care; improvement of the compliance with the program; improvement of the information records; mapping of risky children belonging to the area of coverage; and promotion of the children's health through public actions, especially regarding health education.

The intervention project was part of the project "Qualification of Programmatic Actions in Primary Health Care", which obeys the principles of bioethics and the Resolution No. 196/96 from the National Health Council. Also, it was approved by the Ethics Committee of the Medicine School from the *Universidade Federal de Pelotas*, under the No. 15/2012.

## RESULTS AND DISCUSSION

### The achievements and challenges of the team

During the intervention, 411 (98.6%) children aging from zero to 72 months were registered and monitored. In the first month, 118 (28.3%) children were registered; in the second month, 241 (57.8%) children; in the 3<sup>rd</sup> month, 356 (85.4%) children; and in the 4<sup>th</sup> month, 411 (98.6%) children. The stipulated target was 90% and the team managed to overcome it, mainly because, after the initial mistrust of the parents and professionals, there was a real engagement of the majority of the workers and parents and an intense dissemination work through home visits, community activities, educational actions, and contact with the community leaders, who supported the actions later.

Before the beginning of the intervention, only 17 (4%) of the children had received home visits in the first week of life, in 4 months this number increased to 37 children, of whom 45 were born in the period. The difficulty in providing care to all the children born in the period is related to the local culture, also present in several other parts of Brazil, since many families still believe in the need of 45 days of puerperal period.

In this sense, we first aimed to understand the meaning of this belief for the community to later seek strategies for dialogue and negotiation in health education activities. Learning in the dynamics of work enables the professional to understand the health-disease relationship as an integrally

biological and sociocultural phenomenon, and postulate, from this, a new action. Thus, the pedagogical exercise should establish a dialogue between the disciplinary and non-disciplinary knowledge, and subjectivity and reality experienced.<sup>7</sup>

Among other actions, the work was also carried out with great emphasis on vaccination because having various vaccines that prevent different diseases is an achievement for the Brazilian Health System. Only seven children had a delayed vaccination, which reflects the compliance with the immunization program in Brazil.

The main delayed vaccines were the Viral Triple, the Meningococcal and Influenza. The reasons for the delay were related to the difficulty of mothers to complain with the vaccination, and some of them reported being ill during the vaccination period. Likewise, the team searched the causes of this delay and established, with the parents' help, the most accessible times to carry out the vaccination. Moreover, the need for this preventive action was reinforced, constituting an essential health need for the control of immunopreventable diseases.

Despite all the efforts to achieve the coverage, some places still do not achieve the established goal and one of the factors is the socioeconomic aspect.<sup>8</sup> Other reasons such as lack of access and difficulties in using services, such as the distance of the residence, existence of public transport, working period and the organization of the services. Also, the low vaccination coverage can be a reason.<sup>9</sup> Therefore, it is noticed that the simple offer of the service is not enough for them to be used, and an integrated management strategy is required for the services and sections involved.

Concerning the aspects of clinical evaluation, all the children registered in the program received risk assessment and were mapped, aiming to a better understanding of the needs and the construction of bonds with the families. We have identified cases of mild persistent bronchial asthma, epilepsy, gastroesophageal reflux, left foot agenesis, autism, delay of the psychomotor development, and social risk. These cases were not monitored before, but are currently known by the team, and started receiving at least one visit per month.

Furthermore, the children registered received the assessment of psychomotor development. Two children with learning delay and one with speech difficulties were monitored. In addition to the evaluations, we guide the parents through the exercises to stimulate the psychomotor development. It was an important care strategy to detect early abnormalities, direct actions and refer the child to specialized services to avoid future damage.

Registered children also received monitoring and evaluation of their growth and nutrition. Twenty-one children with weight deficiency and 33 overweight children were monitored. All were referred to the center for specialized nutritional assessment and received monthly

monitoring of the team.

Overweight in childhood is a big concern and has worsened in recent years. This condition can cause numerous complications in the growth and development of the child and also in adult life. Obesity in childhood can lead to various dermatological, orthopedic, metabolic and cardiovascular complications, including high blood pressure. Additionally, psychological implications due to repercussions on self-esteem can arise.<sup>10</sup> These complications should be openly discussed with the parents, who are the main partners to encourage a healthy eating and physical activity.

We performed oral iron supplementation in the children aged between 6 to 24 months. The total number of children in this age group was 164. A child was identified whose mother was not delivering his supplementation even with the medical prescription, since she believed it would not be effective. The child was diagnosed anemia as showed by his blood count. In this case, we take the opportunity to emphasize both the supplementation and the child's diet. The development of these strategies and the child's follow-up was effective for the review of the anemia situation. Furthermore, the team encouraged the need to rethink the way in which health education activities are being addressed considering the need of children for iron supplementation.

Regarding the records, of the 411 children evaluated in four months, 400 (97.3%) had the information on their cards about hearing screening and 369 (89.8%) had records about the phenylketonuria (PKU) test. These tests are not performed at the BHU, and the maternity hospital often does not record them in the child's card. Other data about the child's birth were also not recorded, such as the Apgar score, the red reflex, and in some cases there was no height information.

The absence of birth data worried the team because it was not known whether the child had received adequate care during his birth or whether the problem was related to the lack of records. This situation encouraged the team to think about dialogue strategies with the maternity hospital, seeking to discuss the importance of the birth records for the continuity of care in the FHS. The intervention was not restricted to the service of the team itself, but promoted improvements in other points of the care network.

The child's records are essential for the monitoring of his health. Nevertheless, the absence or incompleteness of data in the child's health book has been common both in the hospital environment and in the FHS units.<sup>11,12</sup>

The difficulty faced by professionals in using this instrument brings reflections on the working conditions of health professionals, as well as on their lack of preparation to deal with this instrument. There is a stressful and overloaded work routine in the maternity hospital, and the filling of numerous forms and bureaucratic procedures demanded by the institution. If the professionals themselves are not

aware of the importance of the Child Handbook, it becomes just another form to fill out. Another aspect to consider is the fact that it is not clearly defined which professional is responsible for the fill of this notebook in the maternity hospital, which leads to the dilution of responsibilities and difficulties in the training and evaluation efforts.<sup>11</sup>

Considering that the notebook is also an instrument of communication, which should be part of the daily work, the lack of registration or the incompleteness of information is a failure in communication and hinders the care provided to the child and his family. The communication between the team members and professionals from different services causes a better evaluation of the child's health status and in more appropriate behaviors. Thus, all professionals who work in the health units need to reconstruct their practices with close relationships as a way of qualifying the care provided to the children.<sup>12</sup>

In this sense, the registration of information in mirror form and in the vaccination card of 100% of the children registered was improved in the FHS. With all data filled, updated records and organized into archives, it was possible to follow up and search for information of the child population in a more integrated and fast way.

Still regarding to the clinical care, the physician and the nurse performed the assessment of the need for dental care in 100% of children aged between 6 to 72 months, totalizing 357 children. However, the first dental consultation by a specialized professional could be performed in only 142 (39.7%) of those children. The basic health unit did not have dentistry services, and the nearest unit which could provide it was located far from the area, and it was difficult to get vacancies, and many families did not have financial conditions for transportation. With these difficulties, being able to provide care for 142 children can be considered a significant result. In addition, the articulation between the services to enable the routing of children to the nearest basic health unit showed a paradigm shift, since before the intervention it was normal simply be satisfied with the existence of procedures that were impossible to carry out.

Even without a dentist, the team did an articulate job that agreed with the responsibility of Primary Health Care. The team was unable to provide dental treatment, but was able to point out the problem and inform the administration about the need for an oral health team in the basic health unit. The Health Secretary, motivated by the exposure of the problem, began an expansion project foreseeing the installation of an oral health team in the Family Health Unit.

Historically, the oral health care programs in childhood prioritized children in the age group of 5 years and teenagers, without directing the care to the stage of eruption of the first teeth, in which also the dental caries occurs mainly due to the habit of nocturnal breastfeeding, high consumption of carbohydrates and sugars, and the lack of adequate oral hygiene.<sup>13</sup>

Therefore, the orientation about the oral health care of the child should begin from the pregnancy, since the access to information and the awareness of the mothers about the necessity of this care influence in the procedures adopted for their children regarding the beginning of oral hygiene, first consultation with a dentist, breastfeeding time, and knowledge about the factors that lead to the development of dental caries.<sup>13</sup>

During the intervention, the parental adherence to childcare increased, which is evident by the decrease of the number of absences in the consultations and in the increase of the number of people participating in educational actions. There were a total of 30 missing children of 411 attended, and all of them received an active search, which represents 7% of the missed consultations. In this sense, the community agent developed an important work, talking to the family about the reasons for missing the consultation and scheduling the next one.

Although the number of missed consultations is low when compared to other services, in which the number of missing consultations reaches 33%,<sup>14</sup> it is known that missing consultations are an important factor in the work of primary care, stimulating the team to rethink their work strategies in order to raise awareness about health promotion, as well as the organization and flexibility to follow the daily life of the habitants of a given territory.

Considering the health promotion strategies, guidelines were developed during the reception, consultations and activities in the community, reaching all parents of the children registered in the program. Different themes were worked out, such as the prevention of childhood accidents, nutritional guidelines, oral health, among others. It was an important strategy that promoted the exchange of experiences and learning, in addition to strengthening the team's relationship with the population.

The educational activities carried out in the community church were attended by approximately 20 people, and it was important to signal a decentralized way of providing health care, strengthening the people's autonomy and their own local intervention capacities. These actions not only addressed the issues related to the child's health program but also the space was used to discuss other community problems, such as dengue and its forms of prevention, the need for prenatal care, among others. Thus, they promoted the strengthening of citizenship and popular participation, increasing the access to the knowledge about health.

In this intervention, the work of the community leaders was fundamental for the parents' compliance with childcare. We had three meetings with the leaders, and their engagement was very effective. They helped to publish the actions, participated in the evaluation of the actions, discussed the difficulties, especially during the assistance of the missing parents, offering support for the community health agent, and suggestions for qualifying the implemented

strategies.

The community life is a very pedagogical place for professionals. Although it demands time and competes with the pressure for more consultations, they contribute a lot to understand the dynamics of people's lives better, to establish partnerships, and to know the surprising other logical ways of organizing life. The knowledge of the local culture and resources enables the practitioner to be faster and more effective his work in basic care.<sup>15</sup> Moreover, developing more effective care strategies constructed in the community reflect their real needs and possibilities for adherence.

The primary care professional has a fundamental responsibility to devote himself to the community work, to meet people in the area, know the realities, establish dialogue strategies and intervention according to the needs of the communities. We understand that the health education activities carried out with the community's participation are necessary to win the battle of the challenges of integral and universal attention.

All the actions planned by the intervention project were executed, although some of them did not have the necessary quality within the 16-week period, such as those carried out in the community during intense heat, rainy periods, which in many occasions prevented collective activities and even planned consultations, which were rescheduled later. We also faced the difficulty of the lack a community health agent in the team, leaving an uncovered micro-area, which required extra efforts from the team and mainly from the agent, which guaranteed the support for the parents of this uncovered micro-area.

Another difficulty was that the area was located on the outskirts of the city, with a very large extension without the support of other teams, being the closest option for uncovered areas by the FHS in Roraima State. This makes it difficult to carry out a planned work, requiring several difficult but inevitable adaptations. In view of the presentation of these difficulties to the management, the urgency in the construction of another BHU was demanded.

Hence, the service training, in this case, was a cause for reorganizations of the team and the daily work processes. The service insertion of the professional in training was important for the team, highlighting the limits of the practice, dismantling and driving the necessary changes in health care actions, which is complex by nature and needs to be constantly evaluated and planned.

## CONCLUSIONS

The development of the intervention increased the coverage and quality of care for children. It has been demonstrated that it is possible to offer quality care to the children when there is involvement of the team, strategies well directed to the needs and planned actions. The organization of the team

for the intervention made it possible to optimize the agenda for a better quality care.

The intervention team provided greater knowledge about childcare and parents. It contributed to a more integrated and organized work that was translated by a greater responsibility of each professional in the community. Before the intervention, the childcare activities were focused on nursing, with the intervention being redirected to the team.

The Specialization Course in Family Health, by its proposal of theoretical/practical teaching based on the case study approach, was important to the student or other professional from another country, so they could understand the culture, the policy of care in basic assistance and the organization of the SUS. It was able to associate theoretical and practical knowledge necessary for health work, which was not restricted to the student itself, but involved the whole team, becoming an important teaching/learning strategy and qualification of the collective practice.

The qualification of a programmatic action as part of an undergraduate thesis was a very important method of teaching it needs to be further promoted by universities, narrowing the relationship between teaching and research, practice and theory, which are necessary for the advancement of the qualification of care in the SUS. This strategy encouraged the team to incorporate the actions of intervention into the routine of the unit, reaching 100% of the indicators, and also to improve other programmatic actions, such as the prenatal and puerperal care, and women's health.

Nonetheless, we reiterate that the debate must be broad and oriented so that the qualification of the actions and broadening access to primary care can be permanent and can involve structural changes in public policies, which promote the guarantee and qualification of human resources in a continuous way, thus strengthening the primary health care as a gateway to health care actions and their coordinator in the network.

Demographic and epidemiological changes point out to the population ageing and the prevalence of chronic diseases. In this scenario, childcare is fundamental and can guarantee future generations of healthier adults and seniors. Thus, we hope that this experience contributes to the work of other FHS teams in childcare, promoting the empowerment of professionals in the partnership with the communities to qualify actions, projects and principles of the SUS.

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