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THE CHILD CARE AS TIME DEFENSE OF THE RIGHT TO HEALTH OF CHILDREN[1]

Raquel Dully Andrade*
Jaqueline Silva Santos**
Juliana Coelho Pina***
Marta Angélica Iossi Silva****
Débora Falleiros de Mello*****

ABSTRACT
The present study aims at analyze narratives of nurses about care in child care practice, by the light of the care and defense of the right to health. This is an exploratory study using qualitative data analysis, from semistructured interviews recorded with 14 nurses working in the Family Health Strategy of the municipality of Passos-MG, being performed thematic analysis of the data. In the results narratives bring aspects of the evaluation of the child, identification situations vulnerable and difficulties in addressing and handling of the cases. Depict complex and intersubjective shapes of defense of child health, requiring responsibilities and enhancement of knowledge and practices to protect and defend the subjects. It is considered that the fundamental elements of nursing care include attention, sensitivity and communication skills to effect care and health advocacy, to respect, protect and implement the rights of the child so full and longitudinal.

Keywords: Child. Nursing. Right to Health. Primary Health Care.

INTRODUCTION

Children are developing beings unable to protect, defend or take care of themselves. They are provided with human rights and the right to health, but need certain conditions so that these privileges can be ensured, as well as actors that care for their quality of life by advocating for the guaranty of their rights, whenever needed.

The Universal Declaration of Human Rights, proclaimed in 1948, exposed that maternity and childhood possess the right to special care. According to the 1966 International Covenant on Civil and Political Rights, ratified in Brazil in 1992, every children, without socioeconomic discrimination — or any other sort of — have the right to protection measures their vulnerable condition requires, guaranteed by their families, the society or the State. The United Nations' Convention on the Rights of the Child, adopted in 1989 and ratified in Brazil in 1990, is an important instrument to protect children's human rights, recognizing them as individuals who possess their own rights, which represented an paradigm shift [1,2].

The Convention on the Rights of the Child defined the principle of comprehensive protection. In Brazil, this was a decisive conception for the adoption of the Comprehensive Protection Doctrine, a reference for the Statute of the Child and Adolescent (ECA), in force since 1990 [3]. These instruments reinforce that children are subjects of their rights and their dignity as human persons must be guaranteed and preserved [2]. The ECA was an important accomplishment, result of the concerted action among social movements, educators, magistrates and several other social actors who defend the idea of a society responsible for better life conditions for children and adolescents [1-3]. Regarding the strength of the conception of comprehensive protection, it should be stressed that putting the purposes of this instruments into practice is a challenge for the country, families, professionals, managers

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*PhD, Professor, Nursing Program, University of Minas Gerais at Passos – FESP/UEMG. E-mail: radully@gmail.com
**Master's student, Nursing Graduate Program in Public Health. University of São Paulo at Ribeirão Preto, College of Nursing - EERP/USP. E-mail: jaque_fesp@hotmail.com
***MSc, Child-Maternal and Public Health Nursing Department, University of São Paulo at Ribeirão Preto, College of Nursing – EERP/USP. E-mail: jcoelho@eerp.usp.br
****PhD, Associate Professor, Child-Maternal and Public Health Nursing Department, University of São Paulo at Ribeirão Preto, College of Nursing – EERP/USP. E-mail: maiossi@eerp.usp.br
*****PhD, Associate Professor, Child-Maternal and Public Health Nursing Department, University of São Paulo at Ribeirão Preto, College of Nursing – EERP/USP. E-mail: defmello@eerp.usp.br

and social groups.

Within this context, it should be emphasized that, among all human rights, there is the right to health. In Brazil, since the 1988 Federal Constitution, health is everyone's right and the State's duty, a basic social right among the conditions of citizenship of the population. Thus, health materialized itself with the creation of the *Sistema Único de Saúde* [Unified Health System] (SUS) that affirmed the universality, comprehensiveness and equity of care, expanding the conception of health to beyond the absence of illnesses, now understood as quality of life[1,4].

In addition, the right to health was highlighted in the constitutional text for it is considered as an element of public relevance, characterized as essential to the exercise of other rights, especially the right to life; it is also noteworthy that the right to health encompasses the right to care, whose practices must respect the principles that shape the human rights [5].

In this context, the Primary Health Care (PHC) is regarded as a guideline to the reform of the health systems [6,7]. It is of great importance the performance of nurses who are in charge of care, health education and communication with several social actors and connect users, families, professionals, managers, communitarian leaders and coordinators of other services and sectors, especially the Family Health Strategy.

In the Primary Health Care, nursing consultation it is important to the children's follow-up, the monitoring of their growth and development, worsening prevention, promotion and maintenance of health, in a systematized and generalist way, centered in the life cycle and in the family context, in order to help children to reach their maximum potential [8,9].

Nursing consultation is based on the principles of universality, equity and integrality of actions, and should be developed in nursing assistance at all levels of health care. The Article 11, subsection I, subparagraph "i" of the Law 7.498, of June 25, 1986, and the Enactment 94.406/87 that regulate, legitimate and establish this activity as belonging to the nurse, a professional who uses components of scientific methods to identify situations of health-illness, prescribe and implement nursing measures that contribute to the promotion, prevention, protection of health, recovery and rehabilitation of individuals, their families and community [10].

Given the children's vulnerability [11], the commitment of professionals, especially health-related, with the protection and defense of children is an ethical precept. Speaking of right to health in documents is not enough; this is a right that must be effectively guaranteed. An attitude for the defense of children's health comprises multiple factors, in a wide comprehension of the health-illness process. In a moment when social determiners have been highlighted in this process, the isolated performance by the professional and the health sector is often unable to solve problems; thus, it is imperative that health professionals, consciously working for the health of those assisted by them, develop a process of communication to establish partnerships with other professionals and sectors, as well as with resources of the community itself. In face of the vulnerability experienced by the child, health professionals should identify alternative resolutions, looking for, according to their professional competences, subsidies to exercise the assistance, educational and managerial functions needed to the promotion of health [1,4].

The purpose of this study was to analyze nurses' reports on child care during well-baby care, taking into consideration the care and defense of the right to health.

METHODOLOGY

This is an exploratory study, with qualitative analysis, that aimed to assess nurses' reports, privileging the way how people understand and experience the processes of life [12]. The field research was conducted in 2012, in Passos, a municipality in the state of Minas Gerais that counts with 17 teams of Family Health Strategy, covering around 73% of the local population. Each team has one nurse, totalizing 17.

All nurses of the 17 Family Health Units were invited to participate in the study; 14 nurses, of 14 units, voluntarily accepted the invitation. One nursery refused it and two were on sick leave. The data collection was based on recorded semi-structured interviews. The interviews were conducted in a way that attempted to stimulate the nurses' reports

spontaneously, allowing them to narrate and reflect on the child care routine and their relationships with the families and the health services, as well as on the production of care and defense of the child's health. The spontaneous interviews also bring about flexibility, depth and interaction between interviewer and interviewee, and may allow for rich and clarifying meetings [12].

During the analyzes of the interviews, there was an attempt to identify and discuss meanings that shaped the reports on the situation and actions relative to the nursing practice in child care, taking as a reference an interpretative method, from the perspective of care and defense of the right to health [13]. The entire material was typed and organized into individual files. The reports were interpreted based on the following stages of the thematic content analysis [12]: a) preliminary reading of the material, seeking to map the meanings attributed by the subjects; b) interpretation of the contents in face of the senses that guided their reports; c) preparation of interpretative synthesis and organization into thematic units of meanings.

The subjects of the study were denominated E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14. The study was approved by the Ethics and Research Committee of the Higher Education Foundation of Passos, MG (Protocol 25/2011).

RESULTS AND DISCUSSION

The age of the interviewees ranged between 29 and 48 years old; 12 of the interviewees were female and 2 were male. The training time varied between 01 and 13 years. The time they had been working in the Family Health Strategy was between 01 and 11 years. As for the specialization, eight interviewees informed that they were not specialized, and six were trained in the following specific areas: Family Health, Mental Health, Hospital Administration, Pedagogical Training in Nursing and Public Health. The specialization in Family Health was referred by four of these interviewees, and one of them holds also a Master's Degree in Nursing in Public Health.

In the nurses' speeches, well-baby care proved to be a moment of care and defense of children's health; in which they assess children and their family and social context, identify vulnerabilities and potentialities, guide and make the service more frequent when needed, besides instructing and forwarding patients to other professionals, services and sectors. The results are presented in the following thematic units: Assessment of the child; Identification of situations vulnerable to the child; Difficulties to approach and conduct the cases.

The assessment of the Child

The assessment includes assessing, identifying, guiding, indicating the periodicity of the consultations and forwarding. The nurse is a mediator among several actors in the process of caring and protecting the child's health. Well-baby care proved to be a moment in which the attention is drawn to the children, their mothers and families. The perception that the mothers and families have an impact on children was identified in the interviews.

> If I notice that a child is not being cared for his or her mother I schedule more consultations. And during the course for expectant mothers I say that it is not only about weighing and measuring, encouraging them to keep with this attitude. (E3)

Well-baby care is understood as a care that goes beyond the acts of weighing and measuring; there is also an attempt to translate this to the mothers, since gestation, in search for the care of the children who are still to come. The report above also depicts well-baby care as an action that is not isolated, but connected with others, as the case of the course for expectant mothers.

Situations involving breastfeeding were pointed during the interviews:

> Then I ask (a nurse talking to a nursing mother) 'Have you ever seen a child whose mother has breastfed him and another whose mother has not done so?' 'Have you ever seen the difference?' 'You work, but you have your rights, it is your child's right'. (E1)

> Many of them come with the baby to the well-baby care and ask: 'Ah, can you see my breast?' (E11)

It is important that the woman knows she can count on a nurse, during breastfeeding; making

her know her rights is part of nursing care. The children's nutrition was also pointed:

> They have a little difficult to start drinking juice, 'when should I have to start giving them juice, when should I have to start giving them sweet baby food?'. So we also have some baby food recipes for the mothers to feel more confident because they, especially primiparae, are very anxious. (E2)

> Some call us when they have a month ahead before returning to work: 'What should I do?' I don't want to stop breastfeeding.' Then we provide them with a schedule that intersperses juice, fruit and breastfeeding. (E7)

> Nutrition is not only about the child, you know, it is the entire house. So I say right away: 'Look, shall we see how your house is?', 'How is the nutrition?', "How is the routine?'. (E1)

Children's nutrition proved to be one of the focuses of care and defense, including guidance and support for the introduction of new supplementary foods after exclusive breastfeeding, as well as the attention to the family and their diet.

The children's follow-up was another aspect mentioned in the interviews:

> For children underweight or almost there you have to schedule more appointments, if you see they aren't gaining weight you have to forward them to a pediatrician and a nutritionist. (E3)

> If they are underweight or overweight, they have to come every week, then every fifteen days and then once a month. (E7)

> If the child is underweight we examine family issues, whether he or she is being breastfed, where the deficiency of nutrition is. If the problem is financial, we forward the case to the CRAS or the NASF. If the problem is clinical, we forward the case to the physician of the PSF or pediatrician and keep monitoring them […] The Cantina da B. (social organization) helps a lot, especially with multimixture. So we have a lot of supporters, population has it. So, they are the contributions that come from many sides. (E9)

The increased frequency of children in the well-baby care was pointed as being motivated by weight loss. This allows for the identification of the weight evolution, assessment of the compliance with the orientations, knowledge on the aspects involved in the situation and the difficulties experienced by the family. Then, it is possible to assess the need for complementary attitudes, such as the inclusion of other professionals in the follow-up. Important actors were: the nutritionist, social worker, the physician of the FHS, the pediatrician and the social organizations. Nurses are mediators, they identify needs and are the starters of other services; they also represent a strong reference, people who are in charge of following up children and family. Nurses' role, thus, configures them as potential lawyers of children's health and a strong support for their families.

The Family Health Strategy has been walking on this way and nurses are important elements for the intermediation of the interdisciplinary relationship because they act as "mediators between customer, multi-professional team, family and community" [14:358]. The nurse's role in the well-baby care was also to support not only children and their families but also other services, regarding primary and secondary care, so that they could perform their job. The duty of defending children's health was explicit in the speeches, when the nurses mentioned that, during the follow-ups, there were celebrations for small gains or achievement of goals. The reports demonstrated involvement, in such a way that the follow-ups seemed to be rewarding.

Identification of Situations Vulnerable to the Children

Well-baby care presented itself as a moment to know the children individually, expanding the attention to their mother and family context. This close and committed approach is a way to defend children's health, allowing for the identification of vulnerability and promoting the access to the necessary attitudes:

> Behind a mother that comes here in despair every week there is something. It is when I ask: 'What's going on?' 'What's going on in your house, are you having some problems? (E1)

The professional searches for information and evidences that can be useful to the comprehensive assessment of the children and their environment, without being restricted to the anthropometric data of psychomotor development. This more comprehensive look by the professional makes parents or legal guardians to report things of different natures,

allowing for the identification of vulnerable situations, which will lead to the pertinent attitudes.

The concept of vulnerability can be understood as the possibilities the subject has to be exposed to factors that lead to problems and risks to health, resulting from aspects related to the subject and the social space, such as the family and communitarian environment, and the access to goods and services [15,16].

In the services narrated, there is a concern with the children's caregivers:

> The grandparents are those who more often bring the children to well-baby care. The parents are more in the work market and the grandparents have to do it. I notice that, in general, the parents tend to be a little bit more careful. I think the grandparents are there to provide some support […] (E9)

> When the sister or the aunt comes, and the child is crying, too much, sometimes they tell that the children miss their parents, so I orientate: 'the time parents have with their kids must be well managed'. I say: 'Ask them to call me and come here to talk', because many times the commentary health agents don't find the patients at home (E1)

The nurse demonstrated having attributed the parents' absence due to their jobs, a potential vulnerability. However, the professional's reaction was contextualized with the reality and devoid of judging, when he understands that the parents need to work and that the grandparents do the best they can. On the other hand, he did not stop to look for a way to work this issue, valuing the available time these parents had and offering the opportunity of talking with them through the phone.

Some reports bring situations of the well-baby care that identify physical signals:

> We have a 4-years-old girl, she's just started to walk. We've identified through the well-baby care that her cephalic perimeter was increasing. We forwarded her to a pediatrician and her treatment got started, she was around 7 months old. Well-baby care has been important to identify alterations. But you can't' do it mechanically. (E8)

Well-baby care is recognized as a care that goes beyond the act of weighing and measuring, in which professionals should be present, attentive to signals, so that they can assess in a way conscious and responsible way, identifying the needs and alterations and conducting follow-ups with the required attitudes. Thus, it must once again stressed that such assistance must carried out by a qualified professional, so that the right to health involves not only the access but also the quality and resolution of the health actions and services that must be guaranteed.

There were reports on the identification of cases of postpartum depression, during well-baby care services, which is an example of the attention given to the mother, not only to the children:

> A mother is depressive, her child needs only about 100 grams to reach the ideal weight. She strives to come, but she's coming, every fifteen days, and brings her child to be weighed. In the first consultation, I don't if it's because the child was born premature, we notice she was falling into depression right away. But because it could be exhaustion due to the delivery, we only observed. Now she's already taking some medicines. In the beginning she stopped bringing the boy, two girls came here with him. I asked: 'Where is she?' 'No, she didn't' want to come.' I said: 'She has to come, the baby is underweight and I have to talk to her'. Then his grandmother came for the other weighing,, I asked again for the mother to come. Then she came, but she was down, weepy. Then she came twice more. The doctor also encouraged her to try to bring her son, to be interested, if the baby is gaining weight. (E7)

Although the postpartum depression was diagnosed, the nurse did not cease to value the presence of the mother during the consultation of the child, which can be seen as of form of defense of the child's health, contributing to the bond and considering the needs of both son and mother, since the child was also vulnerable, being a preterm, underweight and having a depressive mother.

This case suggests that the team understood that it was necessary to protect the child and his relationship with his mother, considering that her presence in the well-baby care represented an opportunity the team had to care for the woman-mother, the child and bond between them. Postpartum depression is a high-prevalence disorder that can undermine the quality of the relationship between mother and child; thus, emotional availability affect the initial relation

between this woman and her baby and, consequently, to the impact of the relations in the development of the child [17].

There are also situation in which aspects about the access to structure and input arise:

> I have a 2-years-old kid who has a cardiopathy. She was brought here to be weighed and I notice she was not ok. She needed an echocardiography and a holter monitor test but her parents had not being able to provide her with these exams. They were calm, but I noticed she was suffering from apnea. What is it to the parents? They don't know what apnea is. Then I got my motorcycle, asked them to wait here and went to the Regulation, explained everything, showed the solicitation of the exams and everything went fine. Now she has already undergone all the exams, received pediatric and cardiac care, and is better, she's ok. (E6)

The vulnerability identified in this speech is related to the aggravation of a chronic pathology, in which the nurse advocated in favor of the child's health, identifying a situation in which the parents could not notice, and from this fact, acted in order to guarantee the access to the care needed, using even his own mean of transportation. Such an attitude represented a support to another professional who solicited the exams, allowing these exams to be carried out in good time.

The everyday life of children who suffer from chronic diseases is modified by therapeutic demands that come from the disease, which demonstrate the need for contact with different professionals and insertion of the family as a partner in the care [18]. In the relations of care, professional and family support is configured, this, as a basis for the integral and longitudinal care and the maintenance of the quality of life of children with chronic condition [19].

Careful, sensitive and committed observation proved to be an important resource for the nurses to perform their jobs, in order to ensure children's right to health.

Difficulties to approach and conduct the cases

In the reports, there are situations in which the nurses experience different types of difficulties to approach and conduct cases presented during the assistance in well-baby care:

> I get lost with some cases we can do nothing about. We try, we instruct, but we can't enter their houses and say: 'You have to do this!'.(E12)

> The child was overweight and it was already harming his health. I gave instructions to his mother, wrote them down for her to show to the pediatrician, she didn't want to. I said: 'Look, he should be crawling already.' 'I waited a little bit more to see if she takes him to the doctor. I was instructed not to put chocolate in his milk anymore, sugar too, but I think it's hard when the mother herself doesn't want to do anything. There was this case last week in which the child was speaking too little. If with 2 years old a child is not speaking well we forwarded he or she to a speech therapist. I instructed his mother to take him to the speech therapist, she didn't like very much: 'Ah, no need for it, he's always this quiet'. I said: 'Ok [...] but do it, just for you not to have doubts about it, to see if he's fine'. (E3)

One of the difficulties of the nurses was to deal with the attitude of family resistance. This type of reaction is especially harmful to children, since they depend on their families to be able to followed up; the absence of such people can result in problems of different sorts; it is necessary, thus, the defense of their right to health.

The nurse sees himself before a child with an identified need and the possibility that this need is not going to be met; thus, it is important the ability of communication with the family, in an attempt to make the latter protect the child. This is not an easy task; this non-satisfactory approach, besides not achieving the results expected, can separate the family from the health team and, consequently, from the child.

Thus, in the care routine, nurses can face hard and complex situations, when dealing with the children's family, which demands careful and discerning hearing [19]. Nurses are able to participate in changes of identities, stimulating the parents' autonomy in the care [20], which tends to occur through the interaction among the subjects involved in the practices, which requires the perception and the respect to the inter-subjectivity [13].

In the relationships with the families, there are difficulties to approach the problems:

> It could be noticed visually; the small head was a little bit different in shape. I found the approach complicated, because I had to say to a woman that

> there was something different with her baby. I notice that in the well-baby care, I had talked to the ACS to know more, but it was in the well-baby care I made the approach, then we forwarded the baby to be examined by a pediatrician. (E12)

The report brings a delicate moment: approaching, with the family, the identification of some alteration in the child's health. It is important that the nurse be sensitive to the complexity this information can represent to the family, being concerned with the search for the most appropriate way to talk about it, constructing a movement in which he or she informs and instructs, simultaneously, but also supports and understands, and expanding the care to the family too. Other reports also illustrate difficulties:

> To make matters worse, the grandmother said: 'they can't even know I came here, neither the mother, nor the father'. Because otherwise it would get worse, maybe they would not even let her protect the child (E3)

> There's this case of a 4 years-old girl who was being violated by her father, and her grandmother brought her to the well-baby care. She said the mother didn't know yet. I didn't know what to do! I asked the gynecologist to examine her. I forwarded her to the Guardianship Council. Her mother works all day long and her father only during the morning. The grandmother heard some comments from the girl, and didn't know how to tell her daughter. It's delicate, we don't know what to do and get stunned. (E6)

The speeches above illustrate cases of sexual harassment against a child. It is intriguing that, in the case reported, the problem was identified and taken to the nurse by the grandmother. This may be an evidence of the difficulty presented by the mothers to identify this issue, and also point nurses of the primary care service as an important reference to the families, while grandmothers represent important defenders of the children in this type of situation.

The nurse seems to be insecure in relation to the most effective attitude in favor of the child, who can be experiencing a serious situation of violation of her rights, which can generate an intense negative impact on her mental health and quality of life, through scars that can remain her entire life. It is clear that there was not mention of a home visit during the process of struggle against this problem. It has to be highlighted that, in one of the speeches, the responsibility was transferred to the Guardianship Council, without the interaction and involvement required in face of the gravity of the case and the protection the child needs in this moment she is experiencing.

There are situations involving observation and respect:

> The mother has HIV, she is being treated, she is healthy. She also takes care of her children very well. We guessed that the child is a carrier, but she doesn't tell us. I ask her questions on her children's health, but she didn't' want to. I respected that, even because she's ill-tempered and if we don't get along well we can't continue with the follow-up. And they're fine, she always bring them to the well-baby care, which let us more relieved. (E9)

The speech above addresses a case in which the nurse had to be an observer, choosing to act based on ethics and respect to the decision of the mother, carrier of the HIV virus, of not talking about the serological condition of their children. The professional is sensitive by thinking that there is going to be more opportunities to continue to following up the children if the limit of information the mother decides to provide is not exceeded. He is concerned with the possibility of getting distant from the mother, which would compromise the identification of aggravation in her children's health.

The delicate character of some situations, the resistance of/by some relatives, the lack of evidences on a possible violation of a child, the secret character of some information related to the child's health, among other issues, emerged as difficulties, during the well-baby care consultations. The quality of the confrontation of these situations will be able to be reflected on the children's health, in such a way that the more committed and the more able the nurse is to handle these problematic situations, the more effective his performance is going to be to protect and defend the children's health.

According to the principles around the reorganization of the practices in the Family Health Strategy, health professionals should be considered as agents to respect, protect and carry out human rights [4,13].

FINAL CONSIDERATIONS

The nurses' experiences show that the situations they deal with, throughout the well-baby care, are characterized by complexities and inter-subjectivity. The exercise of defense of children's health was present in the reports, demonstrating the involvement of these professionals in the protection of health and quality of life of children; however, assistance-related gaps still exist.

Health practices need to be strengthened with the performance of the professionals and the subjects in the preparation of responsibility plans, for a greater comprehensiveness of care and the exercise of the right to health, notably the actions in favor of the child.

The present study contribute from the perspective of the right to health, in order to expose the issues related to vulnerabilities and/or rights violation, and presented some alternatives for the comprehension of the nursing care of children, carried out during well-baby care. Other spaces of discussion and further researchers are required for the expansion of reflections of the defense of children through the integration of practices and knowledge.

A PUERICULTURA COMO MOMENTO DE DEFESA DO DIREITO À SAÚDE DA CRIANÇA

RESUMO

O objetivo do presente estudo foi analisar narrativas de enfermeiros sobre o cuidado da criança na prática de puericultura, à luz do cuidado e da defesa do direito à saúde. Trata-se de estudo exploratório com análise qualitativa dos dados, a partir de entrevistas semiestruturadas gravadas com 14 enfermeiros que atuam na Estratégia Saúde da Família do município de Passos-MG, sendo realizada análise temática dos dados. Nos resultados, as narrativas trazem aspectos sobre a avaliação da criança, identificação de situações vulneráveis e dificuldades na abordagem e condução dos casos. Retratam formas complexas e intersubjetivas de defesa da saúde da criança, requerendo responsabilidades e aprimoramento de saberes e práticas, para defender e proteger os sujeitos. Considera-se que os elementos fundamentais do cuidado de enfermagem englobaram atenção, sensibilidade e habilidade de comunicação para efetivar o cuidado e a advocacia em saúde, para respeitar, proteger e efetivar os direitos da criança, de modo integral e longitudinal.

Palavras-chave: Criança. Enfermagem. Direito à Saúde. Atenção Primária à Saúde.

CUIDADO DEL NIÑO COMO TIEMPO A LA DEFENSE EL DERECHO A LA SALUD DEL NIÑO

RESUMEN

El objetivo de este estudio fue analizar las narrativas de enfermeros sobre el cuidado al niño en la práctica de la puericultura, a la luz de la atención y de la defensa del derecho a la salud. Se trata de un estudio exploratorio con análisis cualitativo de los datos, a partir de entrevistas semiestructuradas grabadas con 14 enfermeros que actúan en la Estrategia Salud de la Familia del municipio de Passos-MG, siendo realizado un análisis temático de los datos. En los resultados, las narrativas traen aspectos sobre la evaluación del niño, identificación de situaciones vulnerables y dificultades en el abordaje y manejo de los casos. Retratan formas complejas e intersubjetivas de defensa de la salud del niño, requiriendo responsabilidades y perfeccionamiento de los saberes y prácticas para defender y proteger a los sujetos. Se considera que los elementos fundamentales de la atención de enfermería incluyen atención, sensibilidad y habilidad de comunicación para efectuar el cuidado y la defensa de la salud, para respetar, proteger y aplicar los derechos del niño de manera plena y longitudinal.

Palabras clave: Niño. Enfermería. Derecho a la Salud. Atención Primaria a la Salud.

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Corresponding author: Raquel Dully Andrade. Rua Capitólio, 697, Muarama II. CEP: 37902-336. Passos, Minas Gerais.

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