



## Interface entre cuidado à saúde da criança e a formação profissional: estudo original

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### ABSTRACT

**Objective:** To understand the implementation of the comprehensive care for children's health in the Family Health Strategy and its interfaces between practice and training.

**Method:** Qualitative, descriptive and exploratory case study, conducted with observation and interviews with medical professionals and nurses. Data were analyzed using thematic content analysis. **Results:** Three categories were formed: Fragility of academic education in relation to child health area in the Family Health Strategy; Disconnection between theory and practice in relation to child health care; Among the many limitations and some possibilities in the implementation of comprehensive practices. **Conclusion:** Permanent education actions are necessary to qualify practices, as well as the expansion of discussions on the subject in academic education.

**Keywords:** Child Care; Family Health Strategy; Professional Training; Health Human Resource Training.

## **INTRODUCTION**

The child health care scenario in Brazil has undergone transformations and is in a reorientation process towards a more inclusive model, where families are invited to have a more active participation based on the perspective of comprehensive care. This change is also anchored in the fact that there are still gaps in child care, organizational and administrative relations, the strengthening of public policies, the work process model, the continuing health education process and the training of human resources<sup>(1)</sup>.

In Brazil, the Ministries of Health and Education, aiming at improvements in the population's health care, reoriented the Model of the Unified Health System (SUS), emphasizing Primary Health Care as one of the important spaces for professional training. Over the years, differentiated public policies have emerged in order to meet the needs of the various population segments. Child health care represents a milestone that strengthens the perspective of comprehensive care. It is an important step for the recognition of children's rights with objectives beyond the reduction of infant mortality, but for the commitment to provide quality of life for the child. <sup>(2)</sup>

Child care in SUS permeates the care network which offers the population continuous care throughout the health service, perceiving the user as a subject with their own subjectivities. <sup>(3)</sup>

Thus, the research question is: Do professionals who care for children in the context of the Family Health Strategy (FHS)

have training that instrumentalizes them to implement comprehensive care for this population group?

This study aims to understand the implementation of comprehensive care for children's health in the Family Health Strategy (FHS) and the interfaces between practice and professional training.

## **METHOD**

This is a qualitative case study, conducted between 2016 and 2017, in the city of Rio de Janeiro - RJ. The thirteen (13) participants of the study were health professionals (physicians and nurses) who had been working for more than six months in one of the eight FHS teams, working directly in comprehensive child care. Professionals who were on vacation or leave during the period of the field work were excluded.

Data was collected through non-participant observation using a guide constructed by the researchers and a semi-structured interview, with open questions in order to obtain perceptions and experiences of the interviewees, addressing issues related to the implementation of actions and strategies of comprehensive child care.

The research was approved in two Ethics Committees, and obtained approval from both under opinions numbers 1,922,876 and 2,054,266, respectively. All guidelines of Resolution 466/12 were met. All ethical aspects were met. To guarantee the anonymity of the participants, the acronyms PM (Medical Professional) and PE (Nurse Professional) were used, followed by

arabic number (1, 2, 3,...) according to the interviews.

Thematic analysis was used to gain understanding of the statements. Thematic analysis made it possible to form three categories: 1) Fragility of academic education in relation to the theme of child health in the FHS; 2) Disconnection between theory and practice in relation to child health care; 3) Between many limits and some possibilities in the implementation of comprehensive practices.

## RESULTS

The participants were health professionals: seven physicians and six nurses. The ages ranged from 25 to 47 years, with a mean of 35 years, revealing young professionals, with training time between 1 year and 16 years.

Regarding gender, eight (61.5%) were female and five (38.5%) were male, demonstrating that the profile of professionals working in Primary Health Care, is mostly women, mainly in nursing, aged 23 to 55 years. <sup>(4)</sup>

Concerning academic background, it was evidenced that eleven of the thirteen interviewees were trained in private educational institutions. Among this total, eight had graduate degrees, and only two had Primary Health Care training.

However, there was no interviewee who had participated in a specialization or residency program for family health. In relation to graduate studies, comparing the results of our research with the results of

the Ministry of Health<sup>(5)</sup>, according to which only 39.53% of physicians had specialization and 37.16% completed medical residency, this study found a degree of specialization of the professionals similar to the national perspective: 3 (43%) of the physicians had specialization, and none had performed a medical residency. In total, 4 (57%) of the doctors had no type of specialization.

Regarding the specialization profile of nurses, 5 (83%) had a specialization course in different areas. When comparing with the MS study performed in 2000<sup>(5)</sup>, which found that only 5.5% of the nurses were specialized in the national scenario of Primary Health Care (ABS), a degree of specialization of the nurses interviewed was observed. Only 1 nurse (17%) did not have any kind of specialization or residency experience.

It is perceived that family health unit professionals experience several difficulties in their daily work, caused, for example, by the rapid expansion of the teams. <sup>(6)</sup>

Participant PE8 had a specialization in FHS management, which differs from the FHS specialization. The graduate program in management aims to train a professional to be capable of developing managerial skills, while the specialization in family health, on the other hand, aims to train the health professional to understand, plan, execute and evaluate family health actions. <sup>(7)</sup>

The work experience of the interviewees in the FHS ranged from 8 months to 15 years; most participants, however, had more than one year of work

experience in PHC. This is an important fact, because it demonstrates that professionals must have experience and knowledge regarding the flow and protocols in order to care for children, considering their uniqueness.

Among physicians, 86% had up to three years of work and 43%, had less than one year. A similar study was conducted by the Ministry of Health <sup>(5)</sup>, and there was no significant change in this profile, which was previously 42.6%. This demonstrates that a high turnover of these professionals in the FHS persists, which compromises the work process, the implementation of the follow-up of comprehensive care to the child and weakens the professional's relationships, the knowledge of flows and protocols as well as continuing education.

Regarding the training time of nurses working in PHC, this is similar to their time working in the FHS. This demonstrates that these professionals, when they graduate, immediately enter the FHS. Among the nurses, 17% had up to three years of experience, and the vast majority, 83%, had more than three years of experience in the FHS. This category of professionals has longer working experience at this level of care and this percentage is growing, which is in line with the research conducted by the MH<sup>(5)</sup>, which shows a percentage of 44% of nurses working for less than a year in the FHS.

## **DISCUSSION**

### **Fragility of academic education in relation to the theme of child health in the FHS**

In this category it was observed that when the participants were asked about their professional education, they raised questions about their unpreparedness regarding the singularities that children demand from PHC. For some interviewees, the training was quite generic regarding child health in PHC. One of the professionals highlighted, for example:

*[...] I had nothing in my training regarding the child's health in PHC or FSH, just a little in the hospital (PM7).*

Thus, it was perceived that the contents related to child care during training, in addition to being reduced, favor care in the hospital environment, supporting the contents that support practices within the scope of PHC. Another interviewee also stated that:

*[...] regarding primary care in child health, or working in the FHS, we had nothing. We learned a little more about the outpatient clinic, which was something that we already did [...]. It was basically that, for two months in the first year and for two months in the fifth year. After, they was always content about the hospitalized child (PM2).*

The vast majority of respondents, 10 out of the 13 participants, reported that the content in their academic training related to the child care in the FSH was lacking, which

today has repercussions on their professional practices and causes a lot of insecurity and dependence on other professionals. Thus, it is verified that the changes suggested by the National Curriculum Guidelines (NCG) shared in 2001 and 2014 were not implemented, since all participants are graduates after the implementation of NCGs.<sup>(8-9)</sup>

The training of health professionals was guided by the biomedical, biological and curative paradigm. The teaching offered by health education institutions was disjointed regarding the real health needs of the Brazilian population, with teaching modalities still in this model.<sup>(10)</sup> Therefore, it is noted that important content is not being highlighted or implemented, for example, the social determinants of health, territoriality, vulnerability and comprehensive care to the child associated with the social and family context, as evidenced in the statement:

*[...] in relation to the health of the child in primary care or in the FHS, we had very little, almost always focused on communicable diseases, diarrheal diseases, flu. A reason for insecurity nowadays (PE1).*

Despite some efforts and advances, the field of Pediatrics in Brazil still focuses care exclusively on the individual and pathology, with greater emphasis on hospitalized children. The reorientation of professional training is urgent and essential, either in the academic sphere or in services through permanent education actions, with comprehensive practices as a

guide. However, this is a major challenge.<sup>(2)</sup>

### **Disconnection between theory and practice in relation to child health care**

The professionals interviewed highlighted a tenuous connection between the content offered and the practices performed. Thus, they reported that the systematic provision of training in services was a priority, to the extent that they do not feel safe and competent to act in practice, outlining comprehensive actions and from the perspective of the singularity of child care in the FHS. These reports were recurrent and can be seen in the following statement:

*[...] there was only one training related to Pediatrics whose objective was to teach the evaluation at the time of the child's first consultation in the FHS. But it turned out that the majority of this training was focused on hospital care (PM11).*

Thus, it was evidenced, both in the researcher's observation and in the reports, that the offer of training specifically related to the child health was reduced. Respondents PE5 and PE8 were the only ones to perform breastfeeding-related training, offered by the project "Breastfeeding-Friendly Primary Care Unit Initiative" - IUBAM. Some of the interviewees also reported that, in addition to alleviating their doubts when they presented themselves during the practices,

they used the health protocols for children outlined by the Secretariat of Primary Care, Surveillance and Health Promotion (SUBPAV). However, no access to relevant documents that should be familiar to professionals working with children was mentioned, for example: Comprehensive Care for Prevalent Diseases in Childhood; and Commitment Agenda for Comprehensive Childcare and the Reduction of Infant Mortality.

The interviewees also did not mention access to health policies aimed at children and the improved support to their professional practices.. Thus, there is evidence of a professional practice with a predominance of technical-instrumental focus, thus indicating the urgent need to expand the supply of in service training that goes beyond the clinical management of the child population. Poor or lacking professional training within the FHS is a reality, even though they are defended as fundamental tools, they are considered insufficient. <sup>(11)</sup> The statements confirm this lack in the provision of training:

*[...] I had no training specifically for child health here in the FHS. Specifically for child health here, I've never had any training. We learn on the job, day to day (PM2). I did not undergo any training in child health in primary care, neither in my training nor in service [...]* (PE6).

In 2007, the Brazilian Ministry of Health with the objective of minimizing gaps in the provision of knowledge instituted the

*Telessaúde Program*, encouraging the provision of reoriented permanent education actions and enhancing the work practices of professionals in the FSH. However, none of the interviewees in this study reported having accessed this program, demonstrating that access to permanent education programs is not an established practice of health professionals. Reaffirming the importance of permanent education actions in the FHS that implement content for the effective operationalization of care.

### **Among the many limits and some possibilities in the implementation of comprehensive practices**

All interviewees were unanimous in reporting that the physical structure of the unit along the lines of Family Clinic (FC) is a very positive factor for meeting the different user demands. The PM11 interviewee, for example, reports that:

*[...] the physical structure in this FC model is a strong point, it is suitable to attend the child and family, with well-equipped offices and a cohesive team.*

The physical structure of the FC allows comprehensive, resolute care, as it is composed of essential elements for the care of users (including the child) and, therefore, to the work of professionals. These data are confirmed in the statement of interviewee PE1:

*[...] in relation to the physical structure, we have*

*various materials available, a practice that provides support to care for and evaluate the child and family. I see that as a strong point.*

The distinction between the physical structure of Primary Care units and that proposed for FC is undeniable, considering: the physical area; the furniture; the presence of air conditioning; the physical area; the furniture; the presence of air conditioning; the internal and external signage in the units; the existence of computer equipment; broadband internet access; the organization of the territory, with digitized maps and the materials, essential to clinical practice. The authors of a study highlight that this differentiated infrastructure is an essential condition for ensuring quality health care. <sup>(12)</sup>

Although the greatest potential for the implementation of the practices was pointed out as the physical structure, six of the interviewees (PE1, PE6, PE8, PM9, PM12, PE13), highlighted that sharing knowledge and experiences among the professionals of the FSH has been fundamental for the effective care, especially when complex issues regarding children with special needs arise, generating many doubts among professionals. This fact is observed in the statement from PM9:

*[...] any doubt in the management of a child I access the specialist nurses and discuss the best treatment options together with them. [This is reinforced by the statement]:*

*[...] in special situations which I have already experience with children I had to ask for help from other colleagues with more experience (PE1).*

Different professionals working in the FHS have a common culture that is the sharing practices and knowledge. In this context, they understand knowledge as a reflexive process of construction and reconstruction, which enables the collective and complementary formation of knowledge, enabling better care for the diverse and complex care needs of the child population. <sup>(13)</sup>

However, there are significant limitations highlighted in the statements. Among others, the absence of a pediatric professional in the Family Health Support Center (NASF) who could be turned to for guidance in complex and specific cases of children with special needs, or major vulnerabilities. This fact was present in the statements of PM3, PE4, PE5, PE6, PM7. One of these statements explains:

*[...] I do not feel supported by the NASF specialist [pediatrician] professional in consultations related to the health of children with special needs. If I had a pediatrician, it would help a lot. In fact, nowadays the exchange of knowledge and clearing up doubts happen among co-workers [...]. I didn't have the training for that, do you understand? (PM7).*

It is also possible to identify in the literature that the absence of some specialist professionals within the NASF, such as the pediatrician, to perform the interconsultation of vulnerable children, compromises comprehensive care, the differentiated perspective in view of the singularity that this population needs, thus impairing holistic care. <sup>(14)</sup>

Other obstacles reported by the respondents (more specifically, PM2, PE4, PE5, PE6, PM7, PE8, PM12, PE13) were: unscheduled consultations, overloading professionals, causing a reduction in the time of each consultation; overlapping agendas; and the multiplicity of professional attributions within the structure of FC. Concerning this, PE8 reported that this excessive demand has been determining the quality of care offered to the child, and it is not possible, for example, to comply with the established protocol.

*The demand is very high, and you try to take care of everything, but in a few moments you may make a mistake, in a few moments you can stop doing some things for lack of time. I come home and think: I forgot the VDRL for the child with congenital syphilis [...] Oh my god! (PE8).*

Actions that have already been extensively analyzed, such as the large volume of care generated by the practice of supply via spontaneous demand and care focused on biomedical actions (diagnosis and medicalization to the detriment of

health promotion actions) are still recurring daily realities and worked on in studies. <sup>(15)</sup>

Thus, it is proven that, even if the FSG establishes guidelines for comprehensive child health care, with emphasis on the promotion and prevention of diseases, there are still many organizational limitations that imply the fragmentation of child and family care.

The absence of a care network that works and which is resolute in order to achieve comprehensive child care was highlighted in the statements of PM7, PE13 and PE4.

*The care network is very time consuming, both in scheduling and in subsequent referrals. And it's common to hear: oh, doctor, is the appointment in a place far away? Because if it, I can't go (PM7).*

Even if there is some improvement in the reference and counter-reference system, Primary Health Care still presents itself as a gateway to the unit, but not for the SUS. This demonstrates the deficiency of the reference network, compromising comprehensive child care; a fact that continues to the present day. <sup>(16)</sup>

The great vulnerability of the ascribed territory is another important difficulty faced by professionals, emphasized in the statement made by PE8.

*The worst is the territory [...] my territory, for example, has many alleys that do not have sewage system, there is no basic sanitation, no decent*



*housing, no drinking water. There are many rats[...]. People drink water from a water fountain, so it is impossible not to get sick [...] (PE8).*

It is necessary to join forces through a solid and effective care network, in an attempt to act in situations that go beyond work of individual health professionals. Working in the FSH with so many social and health vulnerabilities, is perhaps one of the most complex jobs, due to the scope of actions involved in the process. Authors point out that vulnerability is added to biological, existential and social values, challenging care practices in the clinical sphere, in public health, or in social institutions, leading and perpetuating forms of exclusion, segregation and the denial of rights to the susceptible population. <sup>(17-18)</sup>

The fragility or even absence of the provision of training that provides support for quality care to children, especially those with special needs, was recurrent in the statements and highlighted as the greatest difficulty faced by professionals, a fact that contributes to perpetuate insecurity and distance the process of paradigmatic change. PM12 states:

*[...] I think that the lack of training for child health practices is an significant limiting factor, and I do not remember having had any training in these four years in FHS.*

It is important to reaffirm that child care with its singularities is a practice that should be present both in academic training

and in updates through continuing education. Some movement in this sense has occurred which seeks adaptations to the new National Curriculum Guidelines of the Undergraduate Course in Medicine and Nursing.<sup>(8-9)</sup> The theoretical-practical training and supervision of continuing education of primary health care teams are paramount for the adequate performance of professionals in the childcare population. <sup>(19)</sup>

The reality observed in the study demonstrates that there is still a significant demand regarding the implementation of a permanent education, which currently tends to be only theoretical or to focus only on the organic aspects of diseases.

Another limitation referred to is the management of electronic medical records. The participants PE8, PM11 and PE13 indicated that, currently, this is a tool that does not benefit the practice of the professional due to the time required for its completion and the slowness of the operating system. However, PE13 points out that, if there are changes, the electronic medical record can be used as an instrument to support the actions performed in relation to child care, especially in relation to high-risk babies, those who cause more insecurity regarding their management and who today represent an expressive number in the FHS. PE8, for example, states:

*[...] the electronic medical record is also a factor that today hinders and challenges the practices, because it is new, it is in the*

*adaptation process and is still very slow and has issues. Then the consultation takes much longer. [For other interviewees], [...] the electronic medical record has many flaws for child care. [...] And also I don't always have time, because the attendance schedule is always very full, with children and pregnant women (PM11).*

A relevant aspect highlighted regarding limitations refers to the low perception of professionals regarding the importance of the insertion of the family member in the care process. The integration of the family member in the care of the child allows the sharing of care and qualified listening spaces. Thus, it is possible to establish dialogue between those involved, minimize conflicts and negotiate care. <sup>(2)</sup>

Among the interviewees, this extension of shared care was expressed by PM11, when reporting a situation in which it was necessary to explain not only to the mother, but also to another family member, about the importance of exclusive breastfeeding:

*[...] another limitation would be the mothers' level of education in child care. For example, in breastfeeding guidance this happens a lot. There is still resistance to exclusive breastfeeding, and then they start giving tea and foods before the appropriate age. I always try to explain*

*clearly with regard to food, I try to establish a relationship. But their lack of knowledge makes it difficult (PM11).*

The importance of establishing a bond between the team and family members is also highlighted in the literature, referring to specific situations of 'maternity', stating that it is necessary to initiate progressive approximations and that it is up to the health team to understand the mechanisms of a healthy bond between mother, child and other family members. Thus, reducing doubts, frustrations and anxieties in the various situations concerning the child. <sup>(20)</sup>

It cannot be forgotten or minimized that childcare is an action constructed through various and multiple variables. It is emphasized that the childcare in PHC/FHS goes beyond: in order to achieve the singular childcare it is necessary to promote attentive listening, bonding, dialogue, but also the accountability of family members, actively involved in this process. <sup>(21)</sup>

## **CONCLUSION**

From the statements given by the professionals interviewed and the data collected through the two instruments, it was possible to understand the potentialities and difficulties mentioned by these professionals in the operationalization of the comprehensive care line for children and how much training is responsible for leaving gaps in this process.

By revealing the reality of these professionals, the study highlighted the

difficulties and successes experienced, through attentive listening that aimed to support a more sensitive and resolute practice, from the perspective of comprehensiveness. Therefore, the results of this study show the professionals the relevance of perpetuating themselves in the struggle for comprehensive and singular care, regarding children's health.

We also highlight the contribution of this research by defending the need to incorporate content related to the theme analyzed in academic professional training, as well as to highlight the demand for training actions for services to professionals involved in child care. We therefore aim to contribute to the comprehensive care and to the improvement of the quality of care.

Finally, we signal the need to conduct further research on this topic, in order to deepen and unfold the knowledge that aims to provide evidence-based assistance in clinical practice, with regard to comprehensive holistic child care in relation to disease prevention, health promotion and rehabilitation.

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