

Maternal experience in child monitoring in Primary Care: A qualitative approach

Vivido materno no acompanhamento da criança na Atenção Primária: uma abordagem qualitativa

Experiencia materna sobre el cuidado del niño en la Atención Primaria: enfoque cualitativo

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ABSTRACT

Objective: To grasp the maternal experience facing child monitoring by Primary Health Care up to the sixth month of life. **Method:** A study with a qualitative approach grounded on Schütz's Social Phenomenology and conducted from January to July 2018 in the homes of 19 mothers. **Results:** Two thematic units: "The experience of child monitoring by Primary Care in the first six months of life" and "Wishes and expectations regarding the child care received by Primary Care". **Discussion:** The follow-up of the child must take place in the first week of life, because the early neonatal period represents great vulnerability for the newborn. Primary Care is able to organize the monitoring actions through home visits and routine appointments in the Basic Health Unit. **Conclusion:** The mothers identified weaknesses in the monitoring of their children, such as absence of home visits and of some professionals, as well as long intervals between the appointments.

DESCRIPTORS: Children's Care; Governmental Programs; Primary Health Care; Pediatric Nursing; Childcare.

RESUMO

Objetivo: Apreender o vivido materno frente ao acompanhamento da criança até o sexto mês de vida pela Atenção Primária à Saúde. **Método:** Estudo com abordagem qualitativa fundamentado na Fenomenologia Social de Schütz, que ocorreu de janeiro a julho de 2018 no domicílio de 19 mães. **Resultados:** Duas unidades temáticas: "Vivenciado o acompanhamento do filho pela Atenção Primária nos primeiros seis meses de vida" e "Desejos e expectativas frente à assistência à criança recebida pela Atenção Primária". **Discussão:** O seguimento da criança deve acontecer na primeira semana de vida, pois o período neonatal precoce representa grande vulnerabilidade para o recém-nascido. A Atenção Primária é capaz de organizar as ações de acompanhamento por meio de visitas domiciliares e rotina de consultas na Unidade Básica de Saúde. **Conclusão:** As mães identificaram fragilidades no acompanhamento dos filhos, como ausência de visitas domiciliares e de alguns profissionais, e longos intervalos entre as consultas.

DESCRIPTORIOS: Cuidado da Criança; Programas Governamentais; Atenção Primária à Saúde; Enfermagem Pediátrica; Puericultura.

RESUMEN

Objetivo: Comprender la experiencia materna del seguimiento del niño realizado por el servicio de Atención Primaria de la Salud hasta el sexto mes de vida. **Método:** Estudio con abordaje cualitativo basado en la Fenomenología Social Schütz, que se llevó a cabo de enero a julio de 2018 en el hogar de 19 madres. **Resultados:** Dos unidades temáticas: "Experiencia en el seguimiento del niño en la Atención Primaria en los primeros seis meses de vida" y "Deseos y expectativas sobre la asistencia que recibe el niño por parte de la Atención Primaria". **Discusión:** El seguimiento del niño debe realizarse en la primera semana de vida, ya que el período neonatal precoz representa una gran vulnerabilidad para el recién nacido. La Atención Primaria es capaz de organizar acciones de seguimiento a través de visitas domiciliarias y consultas de rutina en la Unidad Básica de Salud. **Conclusión:** Las madres identificaron deficiencias en el seguimiento de sus hijos, como la ausencia de visitas domiciliarias y de algunos profesionales, y largos intervalos entre las consultas.

DESCRIPTORIOS: Cuidado Infantil; Programas Gubernamentales; Atención Primaria de la Salud; Enfermería Pediátrica; Puericultura.

INTRODUCTION

Brazil stands out as the responsible for the population's universal access to health, advocating an integral, public and free system. The Unified Health System (*Sistema Único de Saúde*, SUS) favored numerous advances in social public policies in Brazil, especially for children's health. However, there are demands for qualification in this line of care, and it is in this sense that the country has sought innovations, both in normative aspects and in the implementation of specific programs and actions. Given this context, strategies were adopted, such as reengineering the system, to integrate the public system and seek to overcome the weaknesses, considering local and regional demographic and epidemiological aspects. In 2010, the Ministry of Health established Health Care networks in order to guarantee comprehensive care. *Rede Cegonha* (Stork Network), created in 2011, is one of them, responsible for maternal and child follow-up⁽¹⁾. *Rede Cegonha* has a strategic structure to implement a care network with the purpose of ensuring (i) women the right to reproductive planning, humanized care to pregnancy, delivery and puerperium, and (ii) children the right to safe birth, growth, and healthy development⁽²⁾.

For the process to take place efficiently and with efficacy and effectiveness, *Rede Cegonha* is organized based on four components: prenatal care; labor and birth; puerperium and comprehensive care of the child's health; and logistics system. Therefore, it is able to guarantee continuous assistance of maternal and child health care actions to the population

of a certain territory with adequate quality, correct cost, and accountability for the health results related to this population⁽³⁾.

Based on the principles of *Rede Cegonha*, *Rede Mãe Paranaense* (Paranaense Mother Network) was implemented in Paraná in 2012, defined as a set of actions that involve early recruitment of pregnant women, prenatal care with consultations and exams, risk stratification of pregnant women and children, care in specialized outpatient clinics, and guaranteed delivery through a linking system to the hospital according to the gestational risk. Its mission is to promote safe and quality care during pregnancy, delivery and puerperium, as well as to children under one year of age, seeking to reduce maternal-child mortality⁽⁴⁾.

Considering that the maternal and child population is one of the government's priorities — with the implementation of public policies to qualify care from the gestational period, involving delivery and follow-up of the woman and the child after discharge from the maternity hospital — and the need to evaluate the programs implemented from the user's perspective⁽⁵⁾, this study was conceived, from which the following question emerged: How does the mother perceive the assistance provided to the child by Primary Care during the first six months of life? Therefore, this study aimed at grasping the maternal experience with the monitoring of the child performed by the Primary Health Care service until the sixth month of life, after discharge from the maternity hospital.

METHOD

This is a descriptive study with a qualitative approach based on Alfred Schütz's Social Phenomenology, which is based on the understanding and interpretation of the social action of related human phenomena, in the case of Nursing, to the health-disease process and, mainly, to the situations experienced in different health care scenarios. These elements are obtained through an interview with questions to extract from the interviewee the context of past and present experiences ("reasons why"), with an orientation towards future actions ("reasons for"), as an anticipated act, a projection of the action. In this sense, Social Phenomenology makes it possible to understand the maternal experience from her social relationships⁽⁶⁾.

This study is part of the broad multicenter research project entitled "*Rede Mãe Paranaense* from the user's perspective: Care provided to the woman during the prenatal period, delivery and puerperium; as well as care provided to the child", funded by the National Council for Scientific and Technological Development (CNPq), and carried out in two phases.

The selection of the mothers participating in this study took place in the second phase of the larger study, involving the mothers seen in a reference maternity hospital for deliveries of low-risk pregnant women in a municipality of the Brazilian South region. The inclusion criteria adopted in this stage were as follows: mothers who gave birth in a low-risk maternity hospital and who received exclusive care through the SUS; mothers who did not

resort to the primary care units for child monitoring were excluded.

The interviews were carried out at the mothers' homes after explanation of the research objectives, after the mother's acceptance with the guarantee of anonymity, and after the signature of the Free and Informed Consent Form.

Data collection took place from January to July 2018, by means of a semi-structured interview. The guiding questions were the following: 1) Did you receive a visit from the health team in your child's first week of life? Tell me about this visit. 2) After you were discharged from the maternity hospital, how was your and your baby's monitoring by the health service in the first month after delivery? 3) Until now (after the first 30 days postpartum until the 6th month), tell me how your baby's monitoring by the health service happened. 4) Comment on the access to the Basic Health Unit (BHU) to perform childcare/evaluation of your child? How often? Which professional saw you?

The mean duration of the interviews was 50 minutes, considering the initial interaction and the interview, all recorded on Android mobile devices. At the end, the mother was asked to listen to the recording, guaranteeing her the right to change the information if she felt it was necessary.

Schütz proposes a social investigation through qualitative research to assess people's behavior in their everyday world. This understanding has become a hallmark of health care, since qualitative research seeks to deepen the object under study⁽⁷⁻⁸⁾. In this

way, the "reasons why" and "reasons for" were deepened.

The "reasons why" are related to past achievements, already completed, and which can influence current actions. Based on this context, access was obtained to the daily life of the mothers in the first six months of their children's lives with respect to the assistance received in Primary Care. The "reasons for", on the other hand, are related to the expectations about the assistance they wished they had received.

For organizing and analyzing the qualitative material, the following steps were taken: 1- Attentive and thorough reading of each statement in its entirety to grasp the overall meaning of the experience lived by the mothers; 2- Rereading of each statement to identify common aspects that express the contents related to the "reasons why" and "reasons for"; 3- Grouping of the common aspects according to content convergence to compose the concrete categories; 4- Analysis of the categories to understand the experience lived by the mothers; 5- Constitution of the experience type from the set of "reasons why" and "reasons for" expressed in the analysis of the categories; and 6- Discussion of the experience type in the light of Social Phenomenology⁽⁸⁾.

The study was guided by the principles of National Health Council Resolution 466/12, which regulates research involving human subjects. The participants signed the Free and Informed Consent Form and the research was carried out after approval by the Research Ethics Committee, Opinion No.: 2,053,304 and CAAE: 67574517.1.1001.5231. To preserve

the mothers' anonymity, the descriptions of their speeches used the letter M for "Mother", followed by the number corresponding to the order in which the interviews were conducted.

RESULTS

A total of 36 mothers grouped in five groups according to their residence area were selected to participate in this study. Of these mothers, 6 were excluded for having moved out of the city, 5 due to unavailability and 6 for having missed five telephone calls and two home visits. Therefore, after that process, the sample consisted of 19 mothers, distributed in the municipality as follows: South region: 4; North region: 9; East region: 3; Central region: 1; and West region: 2.

Regarding the characterization of the participating mothers, their mean age was between 15 and 36 years old. Regarding race, 9 (48%) women self-declared as black- and brown-skinned. As for schooling, 6 (30%) had incomplete higher education, and 5 (29%) had complete high school. Regarding marital status, 15 (81%) were married or in a stable union. As far as their occupations are concerned, 12 (67%) were not engaged in any paid activity.

Two thematic units emerged from the analysis of the participants' speeches, the first of which concerned the "reasons why": "Experience of the monitoring of the child by Primary Care in the first six months of life" (Home visit in the first week of life; Child monitoring by Primary Care until the sixth month of life); and the second referred to the "reasons for": "Wishes and expectations regarding the assistance provided to the child by Primary Care" (Wish

for proximity with the professionals and the health unit).

Experience of the monitoring of the child by Primary Care in the first six months of life (“reasons why”)

Among the “reasons why” was the concrete experience of the mothers referring the assistance received in primary care.

Home visit in the first week of life

The home visit conducted by the primary care health professionals must take place in the first week of life of the newborn, as soon as the binomial is discharged from the hospital, mainly in situations where the binomial does not attend the BHU in the first week of life of the newborn. From the reports of the experiences of mothers who received the home visit, it was possible to identify that, on many occasions, this visit did not occur as recommended by the *Programa Rede Mãe Paranaense* (PRMP), because the professionals evaluated the child or only the mother; at other times, there was no evaluation or identification of risk factors, such as the risk of early weaning and the need for guidelines on breastfeeding; in some situations, the professionals only asked if everything was fine, but with little depth in the guidelines.

Yes, I did, from the nurse and the assistants who came to visit. [...] They looked at the breast to see if it didn't have any cracks, they saw if the baby was latching, [...] they also looked at the baby's belly button to see if I was doing the hygiene, I had all this guidance. (M 1)

Yes, I received two visits. They came, they measured, they saw

straight that I was doing the baby's hygiene. (M 3)

Yes, they looked at the baby, they gave guidance because it was hot, they told me not to leave too much clothes on and explained things more carefully. (M 5)

The nurses came. They looked at the baby and examined me too. [...] (M 16)

I received a home visit. I think it was the nurse. She looked at the baby latching, they measured my pressure, she heard the baby's heart. (M 17)

The community agent came. I think a nurse came along with her [...] she just came here to ask if I was fine. (M 19)

Some mothers took their children to the BHU before the team's arrival at their homes.

No, I'm the one who took her to the center [...] because I wanted to make her appointments, I left the maternity hospital and I wanted to go behind, so it wasn't even time for them to go home. (M 6)

[...] no one from the center came in the first week, I was discharged on Sunday and on Monday I already went to take my son to the center, because he was "yellowish", so they already scheduled the appointments and so they didn't come home. [...] (M 8)

No one from the center came home. I had to take my daughter back to the maternity hospital to take the little ear, little foot, little eye test, because when I was discharged they didn't have the doctors who take those tests, and then I went to the center to make appointments, but no one ever went home no. (M 9)

No, nobody came home [...] the people from the center had come

the day before my discharge, when I was still in the maternity hospital; so they left a note with my husband with the day of the appointment to take my son there to see the pediatrician and get the vaccines. (M 11)

However, some mothers participating in this study reported that this visit did not occur, as can be seen in the statements below.

I didn't get any visits, not me, not my son. I was the one who took him to the center (M 4)

[...] no one came home. I went to the health center [...]. (M 7)

No, no one. I'm the one who took him to the center, no one came home (M 10)

I didn't get a home visit, but I was instructed in the maternity hospital that, as soon as I was discharged, I should take the baby to the center. (M 12)

No, with seventeen days I went to the little center, they did childcare on him, they did some exams, he was seen by the pediatrician, he got a vaccine. (M 14)

I didn't get a home visit from the staff of the center, because my son was born on Christmas week, so you see, no one was going to come. (M 18)

With regard to the monitoring of these children by Primary Care, the mothers reported that they experienced childcare of their children, but some stressed the absence of the professional pediatrician in the appointments, replaced by the general practitioner, as reported below.

Child monitoring by Primary Care until the sixth month of life

Some children were monitored by multidisciplinary teams through shared consultations with a general medical practitioner, interspersed with nurses, maintaining the PRMP recommendation of monthly consultations.

[...] at the moment we're without the pediatrician in the center, he's been seen by the general practitioner; one month she goes with this doctor who's not a pediatrician, and another month with the nurse, and has a group for mothers in church (shared child care). (M 1)

[...] in the center there is a pediatrician; she goes one month with her and another month with the nurse; she also goes to see the dentist. But now it's not scheduled anymore, because she's going to be six months old, but before it was every month. They weighed, measured, and made sure everything was fine, but now it's up to me to take her only if she's got something. (M 2)

[...] she has been monitored in the center every month, even yesterday she had a childcare appointment with the nurse. One month it's childcare with the nurse, and the next with the pediatrician; her vaccines are also up to date. (M 3)

[...] we go once a month to the center to do childcare, the appointment with the doctor is more spaced now; at the beginning it was closer in time, we had difficulty with weight, then we controlled weight, so today we do the monitoring more with the girls (nurses); and with the doctor, a little more spaced. (M 8)

As there's no pediatrician there anymore, now that they scheduled it, but he's a general practitioner. But a true pediatrician, like a routine, no. [...]. The nurse

(monitors childcare). Jointly (shared childcare) has one month that is joint activity, the other month is individual. [...] **(M 10)**

Other children were assisted, but outside the recommended interval, as reported below.

[...] scheduled the first appointment when he was about a month old; it was with the nurse and was interspersed with the general practitioner, because we don't have a pediatrician; since he had a problem with weight, he had a lot of monitoring until four months old, every month [...] **(M 4)**

[...] I think I went with my son about three times to appointments with the pediatrician; in these six months, with the nurse was only the first appointment [...] **(M 17)**

[...] So I took him to see the pediatrician, a couple of times in these six months, and he went just once with the nurse and never again [...]. **(M 18)**

As for the mothers' reflections regarding their expectations of child care in Primary Care, the wish for proximity with the health professionals stood out, with more frequent appointments and reduced waiting times.

Wishes and expectations regarding the assistance provided to the child by Primary Care

Wish for proximity with the professionals and the health unit

Some mothers praise the health service, as can be seen below.

[...] health is not bad, the health center's service is not bad. **(M 13)**

[...] I wish that they (professionals) would always be like this, I know you have the good

ones and the ones who are not, but the ones who saw me, thank God, they were very thoughtful. [...] **(M 11)**

However, they recognize that there is lack of professionals for the assistance provided.

[...] I think they needed more doctors in the health centers, to have more appointments, because the demand is large, but there are no professionals. [...] **(M 9)**

[...] many people who use the benefit and few people to serve them [...] they need to have more professionals and that they are committed to helping us. **(M 13)**

[...] in the health area, sometimes you don't have so much expertise, at the time you go to the BHUs, it's a lot of people for very few doctors to serve [...] **(M 14)**

Some mothers complain about the lack of periodicity in the appointments, as well as about the delay in getting service.

[...] Regarding the delivery I have nothing to complain about, now after birth I think they should have more monitoring of the mother and the child too [...]. **(M 2)**

[...] more agility for sure, because the professionals are very slow and the service takes a long time [...]. **(M 19)**

DISCUSSION

Given the importance of child follow-up — which must be started in the first week after hospital discharge through home visits — and of the mothers' reports related to this assistance provided to the child, it was possible to understand the world experienced by these mothers through the “reasons why”.

The visit must take place between five and seven days after discharge from the maternity

hospital, but some mothers were not able to experience this assistance, stating that the first contact with Primary Care occurred when they sought the BHU for the appointments.

The early neonatal period, corresponding to the first week of life, represents a period of great vulnerability for the newborns, so the health care provided to the children must be focused on identifying and coping with the main problems and preventive conducts in order to ensure their proper growth and development⁽⁹⁾.

Comprehensive and multi-professional care of the newborns in the first week after delivery is therefore intended to identify signs of risk that could impair their growth and healthy development; it aims at guiding the mothers about neonatal care, encouraging breastfeeding, and offering support for the difficulties presented, so as to contribute to the reduction of infant morbidity and mortality⁽⁹⁾.

On the discharge day, the maternity hospital where the baby was born must hand in the Child's Health Booklet (or Card) with the recorded data on the health conditions of the mother and newborn, and report to the reference BHU. On the basis of this communication, the health team, especially the nurse, must schedule the home visit⁽¹⁰⁾.

The nurse's home visit aims at observing, evaluating and guiding the mother on child care, working habits and family relationships, as well as on care for the mother in the puerperal period. This came in line with the findings in this study, as the mothers positively represented the actions carried out by the nurse during the home visit. However,

despite the benefits and importance of the visit immediately after the child's arrival at the house, some mothers have not experienced such assistance.

As established by the PRMP, the Primary Care health team is responsible for the care of children living in its coverage area, and must conduct early home visits to puerperal women and newborns who have been discharged from hospital up to the 5th day and schedule an appointment at the BHU⁽¹¹⁾.

In a study conducted in three maternity hospitals in northern France — which participate in the Child Friendly Hospital Initiative (*Iniciativa Hospital Amigo da Criança*, IHAC) and have guidelines similar to those of Brazil regarding the monitoring of the child after discharge from the maternity hospital — the same difficulties were identified as in this study in relation to the care provided by the professionals at the homes and the non-performance of home visits: even with the recommendation of a home visit between the sixth and tenth day of life, this does not occur⁽¹²⁾.

These findings corroborate a study that aimed at describing the actions of nurses in the Family Health Strategy (FHS) regarding the first week in the care of the newborn. It was observed that the actions identified during the first visit to the baby were based on the guidelines to the mothers on basic newborn care, breastfeeding, neonatal triage, immunization and childcare tests, as well as evaluation of the puerperal woman; however, they were sometimes carried out outside the recommended period and with incomplete and outdated guidelines⁽⁹⁾.

On the other hand, some mothers felt taken into account with the presence of the professionals in their homes, saying that they received several guidelines and that they were comprehensively assisted.

With regard to monitoring the growth and development of the child, countless difficulties emerged, such as failure to comply with the monitoring periodicity and absence of specialized professionals. Strategies have been developed in this respect, such as interspersing individualized childcare appointments carried out by general practitioners and nurses associated with shared childcare, in which a multi-professional team linked to the Family Health Support Center generally participates.

This situation is similar to the one found in a study that evaluated child growth monitoring in a BHU of the municipality of Burnadas, Paraíba, which identified that growth monitoring actions are not effectively consolidated, due to the existence of actions carried out in disagreement with what is recommended by the public policies for children's health care, according to the Ministry of Health, pointing out problems such as lack of professionals and of training⁽¹³⁾.

Another study, with the objective of analyzing the care actions carried out by the nurse during childcare appointments, presented close results by verifying that the actions performed by the nurses in the childcare appointments fall far short of those established by the guidelines for children's health care⁽¹⁴⁾.

Primary Care must organize the monitoring actions through childcare, which enables

understanding the child's health situation having as a reference the service closest to the child's residence, with the objective of early detection of risks for possible referrals and/or more frequent monitoring and follow-up by the health team of this unit⁽¹⁵⁾.

The link between the Primary Care team and the family to monitor the child must preferably be initiated from the prenatal period, so that continuity can be established. Growth and development monitoring is part of the comprehensive care provided to the child's health, with the systematic recording in the Child's Health Booklet as for weight curves, length, cephalic perimeter, body mass index, neurolocomotor development milestones, complications, vaccination, guidelines on care (diet, hygiene and accident prevention) and identification of violence. As for periodicity, it must occur monthly, until the sixth month of life^(11,16).

The performance of the multi-professional team, with an emphasis on the nurse's actions in relation to pregnant and puerperal women, is paramount to integrate the newborn into the health services and to extend the conducts beyond the BHU, empowering the mothers to share their doubts and difficulties with regard to safe child care practices⁽¹⁷⁾.

The context of the experiences lived by the mother facing the follow-up of her child by primary care in the first six days of life enabled the emergence of expectations ("reasons for").

The mothers believe that there is a need for more professionals in the health system, trained to work in the services, committed to taking the necessary actions to improve

quality of care. They also wish more proximity with the professionals and agility in the waiting times.

Among other actions, the BHUs need an adequate workforce to achieve the goal of reducing the barriers in the population's access to the Health Care Network. The availability of health professionals with sufficient relevant skills, allocated where they are needed, is essential for the management and provision of health services throughout the national territory. The imbalance in the workforce, as well as geographical misdistribution and, in particular, the lack of skilled human resources in rural or needy regions, is a social and political problem that affects almost all countries. Associated with socioeconomic inequality, this imbalance reduces the population's access to the health services⁽¹⁸⁾.

Therefore, the fundamental challenges to be addressed, when aiming to achieve a more efficient level of health care, can be summarized in four central points: funding, management, access, and qualification of the professionals. Consequently, there is a need for consistent and continuing policies⁽¹⁹⁾.

In a study on the influence of the FHS on the use of health services by Brazilian children under the age of five, it was verified that those living in households covered by the FHS have worse socioeconomic, sanitary and health conditions, but they had estimates of medical appointments and hospital admissions close to those of children without this welfare link, which suggest that the FHS can correct individual and contextual inequalities that affect Brazilians' health by favoring the use of

health services by children, even when they have poorer living and health conditions⁽²⁰⁾.

This research was limited by the time interval related to data collection regarding the experience of these mothers with the home visit in the first week since, as data collection occurred close to six months of life, some memories were not so vivid, which did not favor the deepening of this theme.

CONCLUSION

The development of this study made it possible to understand how the mothers experience the monitoring of their child's growth and development by Primary Care. Implementing the PRMP in child care is important for providing comprehensive assistance in their first year of life.

However, weaknesses were identified in the teams' actions regarding assistance to that population, such as failure to comply with the first home visit to the child up to the fifth day of life. And when the visit did take place, it was not carried out according to the PRMP, as there were incomplete and fragmented guidelines.

In relation to the childcare appointments, most of the mothers experienced this assistance, but some problems were reported, such as absence of pediatricians and inadequate periodicity of the consultations. On the other hand, they highlighted the monitoring by the nurse.

Despite these aspects that need to be discussed, some mothers assess the childcare appointments and the ability of the professionals as excellent, meeting their expectations. However, most of them wish for

greater contact with the professionals working in the care of the child in primary care.

There is a need for a joint action on continuing education with the BHU professionals and managers in order to contemplate the recommended guidelines, providing comprehensive health care to that population. Studies are also needed that address the perceptions of mothers and users of the health services in order to make this care strategy more evident and thus contribute to the child's monitoring.

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