



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

CASE REPORT ARTICLE

REPORT ABOUT THE CONSTRUCTION OF A NURSING PROTOCOL IN CHILD CARE IN PRIMARY CARE

RELATO SOBRE A CONSTRUÇÃO DE UM PROTOCOLO DE ENFERMAGEM EM PUERICULTURA NA ATENÇÃO PRIMÁRIA

INFORME SOBRE LA CONSTRUCCIÓN DE UN PROTOCOLO DE ENFERMERÍA EN EL CUIDADO DE NIÑOS EN ATENCIÓN PRIMARIA

Edmar Rocha Almeida¹, Cinara Botelho Moutinho², Sirley Alves Silva Carvalho³, Maria Rizoneide Negreiros de Araújo⁴

ABSTRACT

Objective: reporting the collective development experience of a child care protocol for Nurses in Primary Health Care. **Method:** a descriptive study of type experience report. It presents the realization of literature over 12 continuing education meetings with agreement and building a set of tables, specific for each month of the child's life in order to organize the clinical routine in child care. **Results:** the frames have a standard structure, dividing the query in six stages: (1) hosting; (2) asking; (3) evaluating; (4) checking the general signs of danger; (5) stratifying risk; and (6) and driving diagnosis. **Conclusion:** it is considered that the protocol is built in a simple operation, but also high theoretical density and can contribute to improved clinical performance of Nurses in childcare. **Descriptors:** Child Care; Children's Health; Pediatric Nursing; Primary Health Care.

RESUMO

Objetivo: relatar a experiência de elaboração coletiva de um protocolo de puericultura para os Enfermeiros da Atenção Primária à Saúde. **Método:** estudo descritivo, do tipo relato de experiência. Apresenta a realização de revisão da literatura ao longo de 12 encontros de educação permanente com pactuação e construção de um conjunto de quadros, específicos para cada mês de vida da criança, a fim de organizar a rotina clínica da puericultura. **Resultados:** os quadros possuem uma estrutura padrão, dividindo a consulta em seis momentos: (1) acolher; (2) perguntar; (3) avaliar; (4) checar sinais gerais de perigo; (5) estratificar o risco; e (6) diagnosticar e conduzir. **Conclusão:** considera-se que o protocolo construído é de simples operacionalização, mas, também, de elevada densidade teórica, podendo contribuir para a melhora da performance clínica dos Enfermeiros na puericultura. **Descritores:** Cuidado da Criança; Saúde da Criança; Enfermagem Pediátrica; Atenção Primária à Saúde.

RESUMEN

Objetivo: presentar la experiencia de desarrollo colectivo de un protocolo de cuidado de niños para las enfermeras en Atención Primaria de Salud. **Método:** un estudio descriptivo del tipo informe de experiencia. Presenta la realización de revisión de la literatura con más de 12 reuniones de educación continua con el acuerdo y la construcción de un conjunto de tablas específicas para cada mes de vida del niño con el fin de organizar la atención de rutina clínica infantil. **Resultados:** los marcos tienen una estructura estándar, dividiendo la consulta en seis etapas: (1) de acogida; (2) pedir; (3) evaluar; (4) comprobar los signos generales de peligro; (5) estratificar el riesgo; y (6) conducir el diagnóstico. **Conclusión:** se considera que el protocolo se basa en una operación simple, pero también de alta densidad teórica y puede contribuir a mejorar el rendimiento clínico de las enfermeras en el cuidado de niños. **Descriptores:** Cuidado de Niños; Salud Infantil; Enfermería Pediátrica; Atención Primaria de Salud.

¹Nurse, Master's Student in Health Sciences, State University of Montes Claros/Unimontes, Primary Health Care Coordinator/City of Taiobeiras. Taiobeiras (MG), Brazil. Email: edsky48@gmail.com; ²Nurse, Resident, Nursing Residency Program in Women's Health of the University Hospital Clemente de Faria/HUCF, State University of Montes Claros/Unimontes. Montes Claros (MG), Brazil. Email: cinarabotelho@yahoo.com.br; ³Speech Therapist, Professor in Sensory Biophysics, Speech Therapy Degree, Federal University of Minas Gerais/UFGM. Belo Horizonte (MG), Brazil. Email: sicarvalho@medicina.ufmg.br; ⁴Nurse, Doctorate in Nursing, Emeritus Professor/School of Nursing and Specialization Coordinator in Family Primary Health Care/Agora Program, Federal University of Minas Gerais/UFGM. Belo Horizonte (MG), Brazil. Email: rizo@nescon.medicina.ufmg.br

INTRODUCTION

In the current context of growing social demands, especially in the health area, investing in children's health is a wise decision, because in addition to avoid the pain and suffering caused by the illness and death of a human being in development, fulfills duties ethical and legal society. If aspire to a better future, a company must invest economic and educational resources in the health protection of children.¹

In Brazil, despite the advances of recent years, still lives with a high infant mortality heterogeneously distributed in the states and municipalities. In Minas Gerais, even with a sharp decline in figures for infant deaths, efforts are still needed to reduce them to levels compatible with developed countries. When analyzing the map of infant mortality, it is possible to identify two main causes: the first linked to pregnancy diseases that lead to premature birth or birth complications and, second, by susceptible infectious diseases to outpatient care. In most episodes, the deaths could be prevented with simple precautions and timely.²

It is a general consensus that ensure access to qualified primary health care services, entered into a more complex network, it reduces infant deaths; so, becomes necessary to organize primary interventions to health in the community focused on the needs of women, mothers and children to promote the full development of children, adults of the future society.¹

In Brazil, the Primary Health Care (PHC), understood as the gateway of the people in the Unified Health System (SUS), assumes the role of providing quality in primary care for children with a focus on health promotion and disease prevention. To this end, it is based on principles such as longitudinality and comprehensive care, first contact and coordination of care. PHC operates in a defined territorial area and thus has the means to identify and accompany children under their responsibility, in order to maintain constant surveillance of the determining factors and determinants of health. An important strategy in this longitudinal process of care is child care.³⁻⁴

Child care is the area of pediatrics that deals with the study of the aspects of

prevention and promotion of child health. It aims at maintaining healthy child so that in the course of the development process, it reaches adulthood without negative health problems interference.³ In fact the Brazilian PHC, the practice of child care was taken over by nurses, and therefore, it provides an opportunity to stimulate the bond and co-responsibility for child health. They are usually scheduled moments of encounter between the professional, the child and its family, and are based on dialogue and health education, organized to accompany the child with longitudinality.⁵⁻⁶

The PHC professionals have objective difficulties in implementing follow-up actions of child health.⁷ Qualitative study conducted with Health Strategy for Nurses of Pindamonhagaba family, state of Sao Paulo, Brazil, aiming to understand the meaning attributed to the nursing consultation in child care, reveals that these professionals perceive themselves unprepared to deal with some situations in child care, in addition to performing without a systematic nursing consultation, with no sequential steps and ordered.⁶ In another qualitative study aimed at describing the routine of care provided by nurses and point out possible changes in the context of municipal FHS of Maceio, State of Alagoas, Brazil, the authors identified that consultations were fragmented and focused only on nutritional and vaccination status of the child, without regard to the promotion of child health, so consider the need to overcome the deficiencies of knowledge and skills professionals.⁵

For child care quality is not enough to provide care, but we need to continuously reflect on its production, because most processes assists involves decisions that are taken from a certain cognitive content.⁸ The literature suggests that the Brazilian PHC in general, it is one of several "nodes" critical low cognitive density of the implemented work processes, ie, clinical decisions are not always supported on scientific grounds, hindering the consolidation of quality PHC.⁴ It is for these reasons that clinical protocols are relevant to a health care system because standardize clinical management based on scientific evidence in order to promote the protection of the professionals involved in the care, and better care for the population.⁹

Protocols can arise from the need for better management organizing health services and systematize the offer of assistance that can result from coming from the SUS guidelines in a specific place or arise from the demand from professionals themselves when trying to solve concrete problems of everyday life.⁹

So, given the need to establish routines based on scientific evidences and facilitate monitoring of child health in PHC Taiobeiras, State of the municipality of Minas Gerais, Brazil, it was decided to design a protocol for child care and the nurses. Therefore, the aim of this study is to report the collective development experience of a child care protocol for Nurses Primary Health Care.

METHOD

This is a descriptive study of type experience report, which is the process of collective construction of a childcare protocol for PHC nurses in the municipality of Taiobeiras, Minas Gerais, Brazil. The labor development scenario is a city in the North of Minas Gerais, with a population of about 31,457 inhabitants. This population has experienced in recent years, remarkable advances in its network of health care, especially in intended for maternal and child care. Taiobeiras in the municipal health services linked to the SUS has its structure based on the PHC with 100% population coverage of 13 multidisciplinary teams of FHS. It is headquarters of the State Center for Specialized Care, part of the state of health care of women and children, offering specialized level of care for pregnant women and children at high risk. Still, still lives with the dissatisfaction of the population with a significant rate of child deaths from preventable causes and the perception on the part of professionals, a non effective work process. Thus, we realized the need to promote change in the network of health services, starting with the PHC which has the greatest potential to impact on the population's health status.⁴

One of the projects addressing the situation was the creation of the Group for the Improvement of Practical Nurses of Primary Health Taiobeiras (GAPE/PHC). It is a model of Continuing Health Education (EPS) based on the Professional Practice Improvement Cycles (CAPP), questioning tool of daily work, aggregating practices

such as: review of medical records, clinical case discussions and simulations. In Capps, the goal is to learn to learn from the topic/selected critical node, setting its key points, seeking resources on scientific evidence, creating a solution hypothesis (protocol or service routine), applying it to reality and evaluating impact.¹⁰

The meetings began in July 2012 and since then the group meets routinely. Each participant has protected professional monthly schedule in his schedule of activities in the PHC to participate in discussions that last about 4 hours. Even though an institutional activity, recognized and supported by management, participation is voluntary, it is understood that, to foster meaningful learning, the learning cycle must be spontaneous and not imposed.¹⁰

Group attended by 13 nurses of Taiobeiras of PHC, with occasional absences, and other invited professionals. Thus, the routines established in the protocol presented were discussed and agreed during meetings of GAPE/PHC and, therefore, it took 12 meetings.

Therefore, the protocol has gone through a long process of collective construction and, therefore, we used the review of the available literature, printed or electronic, searchable without systematic analysis material.⁹ Therefore, met the objectives of the work, as focused on finding already established and recommendations applicable to municipal reality. In this sense, it focused on the analysis and discussion of recommendations of the Ministry of Health, the State Department of Health of Minas Gerais and other relevant entities.

During the process, it was decided to build boards, modeled on an experiment in making these instruments to guide routine visits of medical students.¹¹ Frames are a form of graphical representation of a protocol such as a step by step, with recommendations for professionals to facilitate their understanding.⁹ Tables guide child care consultation for the first year of life, and individualized according to age: newborn 0-29 days and infants from one to 12 months.

RESULTS AND DISCUSSION

It is known that the nursing childcare consultation PHC should be a preparation

time, with global and specific look, whose purpose is to find possible health problems and carry out interventions to promote, protect, restore and rehabilitate the child's health. When childcare is organized into well-defined and overlapping steps, approaches the proposal of Systematization of Nursing Assistance (SAE) by the Federal Nursing Council (COFEN).¹²

The COFEN Resolution 358/2009 establishes that nursing care should be systematic, scientifically based and applied to improve the health of people, constituting the SAE. The resolution proposed data collection, diagnosis, planning, implementation and evaluation as basic steps of a nursing consultation. On the

other hand, clinical experience in nursing care PHC allows the childcare consultation take place in four stages: data collection, nursing diagnosis, nursing prescription and evaluation of consultation.¹²⁻³

Thus, presented the childcare protocol modeling, it was decided to design a structure that meets the norms of COFEN, but also work in the context of the principles and attributes of a strong PHC.⁴ Therefore, it organized a childcare consultation on a schematic model consists of six distinct stages: (1) hosting; (2) asking; (3) evaluating; (4) checking the general signs of danger; (5) stratifying risk; and (6) and driving diagnosis:

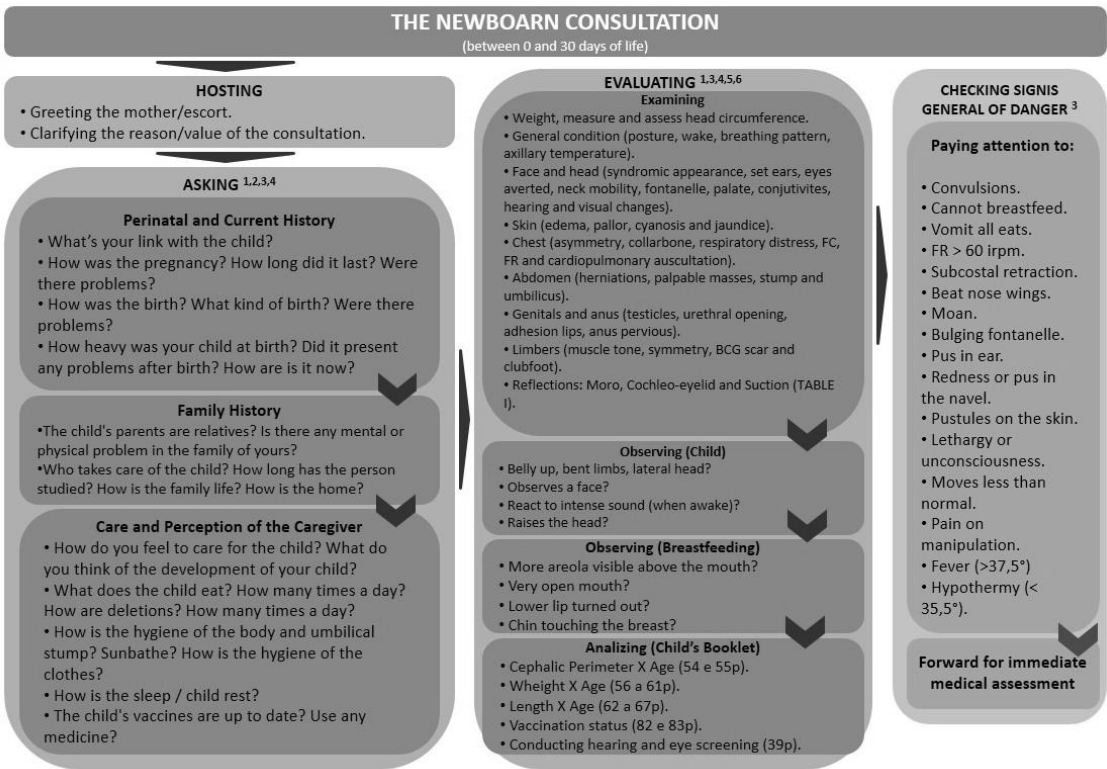


Figure 1: Framework of the consultation of the newborn (part I)

◆ Hosting

PHC, there is a very rich opportunity represented by the monitoring of families over time. This way of organizing health care not only allows the timely recognition of situations that require professional intervention, but also favors the link between health care provider and the child's family. For the development of the bond, essential to implement effective care, the host is an important strategy because it is a caution cognitive technology, built in the relations between professionals and users.^{4,14}

The Protocol, "host" is the time destined to warmly receive the family and the child, perform a qualified hearing and advise

about the importance of childcare monitoring and its scientific basis in order to establish a therapeutic partnership between the family/child and the nurse professional.¹⁴ In literature, one author found good evidence that the professionals, to show empathy, support and conduct qualified listening, able to capture significantly greater family, important to follow the child.¹⁵

◆ Asking

In this step, also known as data collection or nursing history, there is the time when you get to know and evaluate the child's birth conditions, complications during the pregnancy and family history.¹⁴ According to literature review already cited, there are no

studies that demonstrate the effectiveness of data collection on child care, as a way to detect problems early. Nevertheless, there is consensus that the systematization of the interview is essential for quality childcare.¹⁵ Thus, "asking" is the period of nursing history, where the professional carries out various questions in order to investigating the family history and the child.

In this situation, it is helpful to have facilitators' questions to lead the data collection process and introduce, according to age group, relevant issues, such as deletions, nutrition, sleep pattern, behavior, and risk situations among others. Also, it is recommended that this script is structured in a systematic way to assess risk factors.¹⁵ In view of these considerations, the basic script in this protocol was developed from a review of several proposals.^{2,12,14} We opted for the construction of a simplified and focused script in open questions in order to better assess the child's history and family, dividing it into three blocks: perinatal and current history, family history and perception of care and caregiver.¹⁶

◆ Evaluating

"Evaluating" was the term chosen to represent the moment of realization of the child's systematic physical examination. In the protocol, regarding the evaluation of the child block comprises four steps. The first, called to examine, is the moment of systematic physical examination performed by the nurse. The second and third steps are for the observation of developmental milestones and breastfeeding, respectively. Finally, there is the step "analyzing" which provides for the use of the Child Health Handbook.

The first step is the moment when the professional nurse develops a systematic and thorough physical examination in order to analyze the child's health. In the nursing context, it should be considered a physical exam characterized by high accuracy and low specificity. This means that the main purpose of the approach is to identify the nature of the organic change, but recognize it and refer to it for the professional who will implement the appropriate therapy. To this end, it makes use of basic techniques, such as inspection, palpation, percussion and auscultation.¹²

It is known that the realization of complete physical examinations on all child

visits is not recommended because this conduct raises little sensitivity for identifying problems early in life.¹⁵ Thus, the protocol was structured for a complete physical examination only the first child consultation, as recommended by the Ministry of Health.¹⁴ In subsequent queries, scripts aim to optimize the use of time, focusing on during the physical examination the most important aspects.¹⁵

It is emphasized that the identification of changes in the physical examination is based on a comparison of standardized findings and standards with its variations, without ignoring the individuality and the context of each case. For uniform procedures, given that the parameters change according to the literature, it was decided to include in the protocol clinical parameters for assessing child.¹²

In the second stage, it provides for the assessment of child development. Simply put, it can be said that development is the process of acquiring more complex skills, which make an independent and autonomous child. However, this concept is limited because, according to the study area, it is possible to emphasize other aspects, also important, such as emotional and cognitive.⁷ To conducting surveillance of child development with quality PHC, it is necessary that professionals possess basic scientific foundation and recognize normal aspects and behaviors that might suggest a problem.¹⁶

Follow the child's development is a complex concept and requires assessment tools that are objective, but also that address biological risk factors, social and economic.⁷ On the other hand, the development of surveillance tools should be based on methodologies simple, feasible, socially acceptable and scientific foundation.¹⁶

There are many development monitoring instruments, which are differentiated by the level of complexity and the vast majority works with so-called milestones of child development. Reflect the development of adaptive behaviors, which, in humans, tend to have a relatively standardized sequence of acquisition in the general population. However, studies have shown variation in acquisition due to factors such as gender, study population, which reinforces the standardized instruments are only screening test.⁷

Thus, the protocol, standardized to the development of surveillance facility provided in the child's health booklet, which calls for investigation of risk factors, listening to the opinions of parents and the evaluation of possible phenotypic changes. The practicality of working the instrument and ease of access were determining factors in choosing.¹⁷

The third stage of the child's evaluation time is geared specifically to the situation of breastfeeding. The scientific evidences of today are clear about the benefits of breastfeeding for mother and child, also on the effect of the correct approach to the health professional in the maintenance of breastfeeding. For these reasons, it was included a checklist of the major signs of adequate suction technique to the flowchart of six months query.¹⁴

The time to review concludes with the step "analyzing" which corresponds to the fill and assessment charts. Currently, the most appropriate way to track children's growth is the periodic logging of anthropometric data in the child's health booklet. Therefore, measures are being placed as points in the longitudinal mode chart and, when joined, form a line that reflects the child's growth. The graphics cutoff points are z scores, indications of standard deviation units from the median value, as recommended by the World Health Organization (WHO). We recommend the completion and evaluation of graphic head circumference x age, weight x age and length x age. Anthropometric data to be

recorded on the chart are collected during the physical examination.^{14,17}

Even in the "evaluating", the protocol recommends a systematic analysis of the child's vaccination status. The child care is an opportunity to promote the immunization of children in order to improve vaccination coverage and thus reduce the incidence of preventable diseases to immunobiologicals. Also, at this stage, it was included in the newborn flowchart, verifying the accomplishment of auditory and visual newborn screening.¹⁴

♦ Checking general signs of danger

The movement called "checking danger signs" is the verification stage of clinical conditions which indicate immediate medical intervention. It is known that the first child's life year is a period considered critical because the immaturity of the immune system can provide the unfavorable and rapidly evolving infections. When treatment is not implemented in a timely manner, the child may die early. It is interesting, therefore, that health professionals have a watchful eye, since the serious infectious conditions have insidious progression and general clinical signs. To facilitate the identification of children in need of early care, they have developed the so-called general danger signs, which are indicative of immediate medical evaluation. The Protocol, the danger signs are different for children under two months and older children. Thus, it is another tool that aims to equip the nurse in identifying children who deserve prompt attention.²

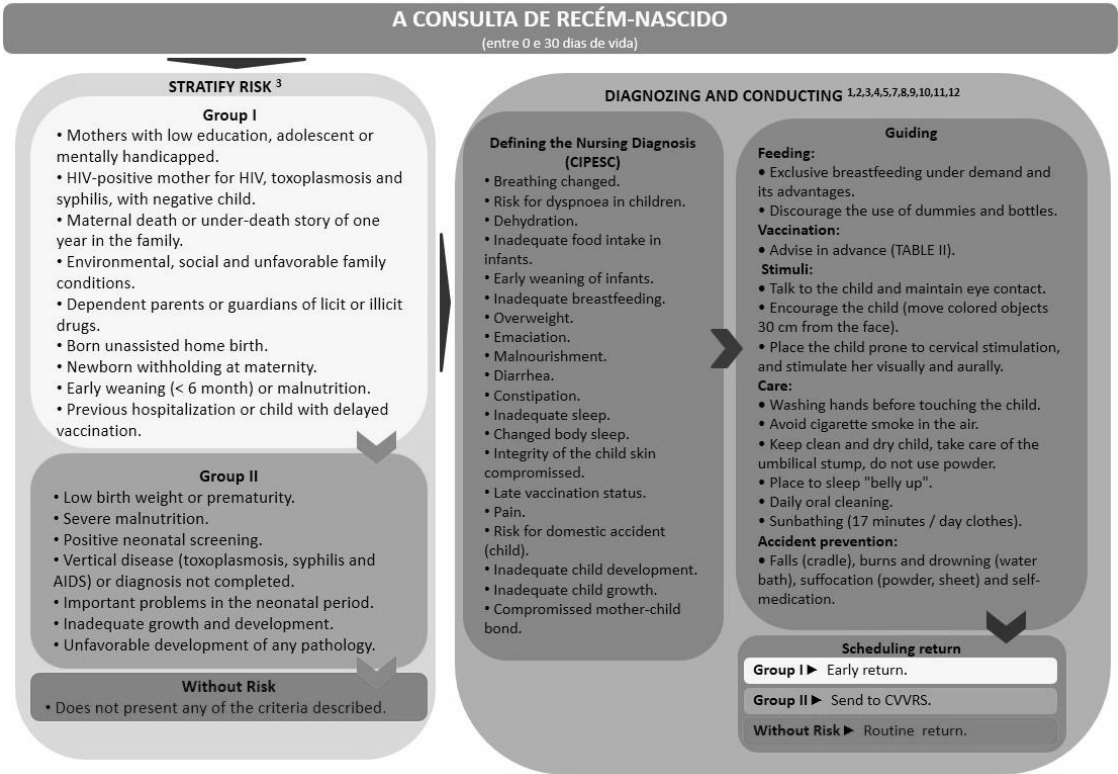


Figure 2. Framework of the consultation of the newborn (part II)

◆ Stratifying the risk

A PHC quality must necessarily stratify the risk of the population for which it provides care. This means separate people and groups with similar needs that require specific features. Thus, it can perform an individualized clinical management of people according to their risk and rationalize the agenda of professionals, so that the people most at risk receive special attention.⁴

Thus, "stratifying risk" is the process of identifying factors that will determine the itinerary of the child within the health care network, or if it will be accompanied only by PHC or need the secondary reference. In the proposed protocol, we adopted a way to stratify risk identifying some vulnerable conditions of the child population that require closer monitoring or even care sharing with experts. Thus, children are divided into three risk groups: group I set up situations that impose an PHC care more carefully; group II where the action is shared between PHC and experts; and without risk group is children who do not require special care.²

◆ Driving diagnosis

This is the last frame of each flowchart and includes the definition of the nursing diagnosis, the guidelines and the schedule of the return. It is understood by nursing diagnostic interpretation of data collected during the consultation that results in

decision making about diagnostic concepts, in order to support the selection of interventions to achieve improvement in the health of the individual, family or community.¹³

The taxonomy diagnostic selected to be incorporated into the protocol was established by the International Classification of Nursing Practice in Community Health (CIPEsc), from the experience made in the context of the PHC to Curitiba, state of Parana.¹⁸ Therefore, the aim of adopting CIPEsc the protocol was to better organize the clinical reasoning of nurses, whereas, in the context of PHC, are professionals with important and effective clinical performance as existing evidence in several studies.⁴

In the "dring the diagnosis", there is another point that specifically addresses the anticipated advice. For many authors, there are uncertainties about its effectiveness, but it is a key element of childcare, as most parents expect to receive recommendations of health professionals. On the other hand, the literature documents the effectiveness of early guidance in improving social skills and cognitive development of the child, increasing the bond between country and children, improvement in oral health care, health food development and promotion of breastfeeding.¹⁵ According to the Ministry of Health, there is strong evidence to justify guidance on the sleeping position, prevention of respiratory viral infection,

diet and prevention of unintentional injuries. For these reasons, the protocol has been incorporated into various guidelines, including consecrated by the practice of child care, such as immunizations, baby care and early stimulation of development.¹⁴

The picture ends with the definition of the child's return, which will take into account all the steps discussed above, but mostly risk stratification in order to ensure careful with certain technological density in the right place with the right quality and humanized form.^{2,4}

FINAL NOTES

A protocol of routine visits to PHC Nurses built collectively, easy to apply scientifically based and represents a major advance in the systematization of nursing work processes. During his development process, he realized the importance of the pact conducts between peers and based on the reality of the health care network in order to create an instrument that can effectively be used to improve professional performance and, consequently, the health of population.

It is observed also that the methodology used in GAPE/PHC for the collective construction of the clinical protocol and, concomitantly, the continuing education of professionals involved is effective and potentially able to promote positive changes in the work process. It can be inferred that this fact is the methodological dynamism and also the possibility of creating a collaborative environment among professionals, where knowing and doing of each are valued, forming an adequate space to promote meaningful and problem-solving learning when working from the concrete reality of health services.

ACKNOWLEDGEMENTS

To the Nurses of Primary Care of Taiobeiras, for the opportunity of collective construction of knowledge presented.

REFERENCES

1. United Nations Children's Fund. The state of the world's children 2008: child survival. Nova York: United Nations Children's Fund; 2007.
2. Minas Gerais. Secretaria de Estado da Saúde. Atenção à Saúde da Criança. 3 ed. Belo Horizonte: Secretaria de Estado da Saúde de Minas Gerais; 2008.
3. Del Ciampo LA, Ricco RG, Daneluzzi JC, Del Ciampo IRL, Ferraz IS, Almeida CAN. O Programa de saúde da família e a puericultura. Ciênc saúde coletiva [Internet]. 2006 July [cited 2013 Dec 10];11(3):739-43. Available from: <http://www.scielo.br/pdf/csc/v11n3/30988.pdf>
4. Mendes EV. O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família. Brasília: Organização Pan-Americana da Saúde; 2012.
5. Silva ICA, Rebouças CBA, Lúcio IML, Bastos MLA. Nursing consultation in childcare: a reality of care. J Nurs UFPE on line [Internet]. 2014 Apr [cited 2014 June 19];8(4):966-73. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4241/pdf_4912
6. Campos RMC, Ribeiro CA, Silva CV, Saporoli ECL. Nursing consultation in child care: the experience of nurses in the Family Health Strategy. Rev Esc Enferm USP [internet]. 2011 June [cited 2014 Feb 14];45(3):566-74. Available from: http://www.scielo.br/pdf/reeusp/v45n3/en_v45n3a03.pdf
7. Alves CRL, Moulin ZS, Santos LC. Atenção à saúde da criança: aspectos básicos. Belo Horizonte: Nescon/UFMG; 2013.
8. Faria HP, Werneck MF, Santos MA, Teixeira PF. Processo de trabalho em saúde. 2nd ed. Belo Horizonte: Nescon/UFMG; 2009.
9. Werneck MAF, Faria HP, Campos KFC. Protocolo de cuidado à saúde e de organização de serviço. Belo Horizonte: Coopmed; 2009.
10. Silvério JB. Programa de educação permanente para médicos de família. Rev méd Minas Gerais [Internet]. 2008 [cited 2013 July 02];18(Supl 4):60-6. Available from: <http://rmmg.medicina.ufmg.br/index.php/rmmg/article/view/104/84>
11. Santos NP. Recurso semiótico para otimizar o desempenho de estudantes para consultas de puericultura: uma experiência piloto. Rev bras educ méd [Internet]. 2011 Jan [cited 2012 Dec 16];35(1):122-31. Available from:

<http://www.scielo.br/pdf/rbem/v35n1/a17v35n1.pdf>

12. Fujimori E, Ohara CV. Enfermagem e a saúde da criança na atenção básica. Barueri: Manole; 2009.

13. Brasil. Conselho Federal de Enfermagem. Resolução n. 358/2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências [Internet]. [cited 2014 Feb 16]. Available from:

http://novo.portalcofen.gov.br/resoluco-cofen-3582009_4384.html

14. Brasil. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Saúde da criança: crescimento e desenvolvimento. Brasília: Ministério da Saúde; 2012.

15. Blank D. A puericultura hoje: um enfoque apoiado em evidências. J pediatri [Internet]. 2003 maio [cited 2012 Oct 05];79(Supl 1):S13-22. Available from: <http://www.scielo.br/pdf/jped/v79s1/v79s1a03.pdf>

16. Organização Pan-Americana da Saúde. Divisão de Promoção e Proteção da Saúde. Manual para vigilância do desenvolvimento infantil no contexto da AIDPI. Washington: Organização Pan-Americana da Saúde; 2005.

17. Brasil. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Caderneta de saúde da criança. 8th ed. Brasília: MS; 2013.

18. Cubas MR, Albuquerque LM, Martins KM, Nóbrega MML. Avaliação da implantação do CIPESC em Curitiba. Rev Esc Enferm USP [Internet]. 2006 June [cited 2014 Jan 10];40(2):269-73. Available from: <http://www.ee.usp.br/reeusp/upload/pdf/248.pdf>

Submission: 2015/06/30

Accepted: 2016/12/15

Publishing: 2016/02/01

Corresponding Address

Edmar Rocha Almeida
Coordenador de Atenção Primária à Saúde
do Departamento de Saúde e Saneamento
de Taiobeiras
Avenida Caiçara, 1574
Bairro Sagrada Família
CEP 39550-00 – Taiobeiras (MG), Brazil