Esc Anna Nery (print)2013 Sep-Dec; 17 (4):772 - 780

INTEGRALITY OF ACTIONS AMONG PROFESSIONALS AND SERVICES: A NECESSITY FOR CHILD'S RIGHT TO HEALTH

Integralidade das ações entre profissionais e serviços: prerrogativa ao direito à saúde da criança

Integralidad de las acciones entre profesionales y servicios: prerrogativa para el derecho a la salud de los niños

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Submitted on 05/09/2013, resubmited on 07/12/2013 and accepted on 07/22/2013

ABSTRACT

Objective: To analyze the testimonies of nurses concerning the integrality of actions within child- and family-centered care, grasping strengths and weaknesses in a search for the defense of children's right to health. **Methods:** Exploratory study using qualitative thematic analysis based on care and the right to health. Semi-structured interviews were conducted with 14 nurses working within the Family Health Strategy in Passos (MG), Brazil. **Results:** The testimonies show aspects related to communication between professionals and services, gaps in partnerships and limitations in terms of integrality and inter-sector actions. Positive and negative partnerships were reported, while the joint work between professionals and services was acknowledged. **Conclusion:** Broadened approaches designed to provide integral care and to construct a practice that avoids gaps in partnerships and that increase integrality and inter-sector cooperation among health actions are important, especially in the face of a set of laws and programs designed to provide integral protection to children.

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

RESUMO

Este estudo teve como objetivo analisar narrativas de enfermeiros sobre a integralidade das ações voltadas às crianças e suas famílias, apreendendo fortalezas e fragilidades em busca da defesa do direito à saúde. **Métodos:** Estudo exploratório com análise qualitativa temática dos dados, fundamentado no cuidado e direito à saúde. Foram realizadas entrevistas semiestruturadas com 14 enfermeiros que atuam na Estratégia Saúde da Família de Passos-MG. **Resultados:** As narrativas mostram aspectos relacionados à comunicação entre os profissionais e os serviços, lacunas nas relações de parcerias e limites na integralidade e intersetorialidade das ações. Parcerias positivadas e não positivadas foram mencionadas, sendo valorizado o trabalho conjunto entre profissionais e serviços. **Conclusão:** Abordagens ampliadas para um cuidado integral são importantes para construir perspectivas de trabalho que evitem lacunas nas relações de parceria e ampliem a integralidade e intersetorialidade das ações em rede, especialmente diante do conjunto de leis e programas que visam à proteção integral das crianças.

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

RESUMEN

Objetivo: Analizar los relatos de enfermeros acerca de la integralidad de las acciones dirigidas a los niños y sus familias, captando fortalezas y debilidades en la búsqueda de la defensa del derecho a la salud. **Métodos:** Estudio exploratorio con análisis temático cualitativo, fundamentado en el cuidado y derecho a la salud. Fueron realizadas entrevistas semiestructuradas con 14 enfermeros que actúan en la Estrategia Salud de la Familia. **Resultados:** Los relatos muestran aspectos relacionadoscon la comunicación entre los profesionales y los servicios, las brechas en las relaciones y los límites en la integralidad e intersectorialidad de las acciones. Relaciones positivadas y no positivadas fueron mencionadas. **Conclusión:** Enfoques ampliados para un cuidado integral son importantes para construir perspectivas de trabajo que eviten lagunas en las relaciones de colaboración y amplíen la integralidad e intersetorialidad de las acciones en red, especialmente frente al conjunto de leyes y programas que tienen por finalidad la protección integral de los niños.

Palavras-clave: Niño; Enfermería; Derecho a la Salud; Atención Primaria de Salud; Atención Integral de Salud.

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DOI: 10.5935/1414-8145.20130023

INTRODUCTION

The child is a being of rights but, at the same time, too fragile to develop self-care and enable its own protection and defense[1]. Given this vulnerability, we consider it to be an ethical precept that every adult is committed to act in favor of the protection and defense of children.

Health practices need to be strengthened through the work of professionals and subjects, moving toward the construction of accountability[2], for greater integrality inhealth care[3] and the exercise of rights in the healthcare field, highlighting actions on the behalf of children, who are especially vulnerable in the exercise of their own advocacy[4]. We note that discussion regarding humanization, integrality of care, and health promotion, as well as the principles of quality of life, equality, autonomy and rights of users, has resulted in strategies to reorganize health care[2-4].

Integral care is recommended in Brazil by the Family Health Strategy (FHS) and refers to care provided to individuals and families over time, to the development of partnerships to encompass the determinants of the health-disease continuum, and to find definitive responses to address the population and community needs[5].

In the spheres of Primary Health Care (PHC), the FHS, and within the context of the Brazilian Unified Health System (SUS), professionals need to develop family-centered care, based on bonds, longitudinally, and inter-sector cooperation, and seek integrality in healthcare. The care delivered in the scope of childcare may have a limited impact if it does not take into account that the parents, families, community and all the caregivers of this population, including the professionals of various fields, play an essential role in protecting child health. There are, however, gaps in the healthcare system that hinder the accomplishment of integrality in health actions. From this perspective, nurses play an important role in actions directed to childcare, given their direct work in providing care to children and families and also because nurses have managerial responsibilities in health units, occupying an important space as mediators in the city's service network. Hence, this study's objective was to analyze the testimonies of nurses concerning the integrality of actions directed to children and their families in the context of the Family Health Strategy, grasping strengths and weaknesses in the defense of the right to health.

METHOD

Exploratory study with qualitative analysis of data based on the conceptual framework of care and right to health, which addresses care interventions with a concern to overcome a technicalview, with the strict instrumental application of biomedical knowledge to particular healthcare situations[6]. The understanding is that care and the defense of rights seek dialogic-based healthcare, that is, healthcare based on the knowledge and values of the different subjects involvedand sensitive to the practical meanings,and ethical, moral, political and affective senses of demands and interventions in the health field[6].

This study analyzed the narratives of nurses, emphasizing the way people understand and experience the processes of life[7]. The field research was conducted in Passos (MG) Brazil. The city has a Full Enlarged Primary Healthcare System. The Family Health Strategy (FHS) was initiated in 1997 and currently the city has 17 teams covering approximately 73% of the local population. Each team has a nurse, which totals 17 nurses in the FHS.

The nurses in all 17 family health units were invited to participate in the study while 14 nurses from 14 units voluntarily consented to participate. One nurse refused to participate and two were on sick leave. Data collection was based on recorded semi-structured interviews. The following guiding questions were asked: How is care delivered to children organized here in your workplace?; Would you tell me ofa situation in which you experienced the need to act in the defense of a child's health?; How does partnerships benefit children? What about the inter-sector relationship of the health service with other areas that is intended to ensure the rights of children?; How do you understand the defense of children in regard to healthcare in the routine of your practice in the Family Health Strategy?: What knowledge, skills and/or attitudes do you think are important for nurse to develop the defense of children's health in your work context?

In a brief characterization of the study's participants, we highlight that the ages ranged from 29 to 48 years old; 12 were females and 2 were males; time since graduation ranged between 1 and 13 years; experience in the FHS ranged from 1 and 11 years; 8 interviewees reported no specialization and 6 reported specializations in the following: Family Health, Mental Health, Hospital Administration, Pedagogical Qualification in the Nursing Field, and Public Health. Specialization in Family Health was reported by 04 of the participants and 01 of them also reported obtaining an MSc in Public Health.

We sought to perform the interviews by encouraging nurses to freely provide their reports, allowing them to narrate and reflect upon the routine of the care they provide to children and their relationships with the families and with the health services, as well as on the production of care and defense of child health. The free interview brings flexibility, depth and interaction between the interviewer and interviewee, enabling rich and clarifying meetings[7]. The interviews were performed individually and by a single researcher.

During the analysis of the interviews, we identified and discussed the organization of the meanings of reports concerning situations related to the integrality of child health actions, taking as a reference an interpretative trajectory from the perspective of care and defense of the right to receive healthcare[8]. The entire material was transcribed and organized into individual files. The stages of content thematic analysis were followed in the interpretation of reports[7]: a) preliminary reading of the material seeking to map the meanings assigned by the subjects; b) interpretation of content in light of the meanings guiding their reports: c) development of the interpretative synthesis and organization into thematic units of meanings.

The study's subjects were designated N1, N2... N14. The study was approved by the Institutional Review Board at *Fundação Ensino Superior de Passos*, protocol No. 25/2011.

RESULTS

The results that emerged from data analysis are presented according to the themes: Communication between the professionals and services; Gaps in relationships of partnerships; Limitations to the integrality and inter-sector cooperation of actions.

Communication between the professionals and services

The communication process is highlighted as essential for the various interactions in favor of the child's health and wellbeing and that of the family, both among the professionals within a unit and between the professionals and other services.

> *I always tell the girls [CHA]: 'Listen, you can do this, you can provide guidance. They call and the nursing auxiliary calls also. They get the phone; if necessary they call the police, the social worker, NASF. (E1)*

> *The physician called me to ask, because he was a little insecure about what I thought of him prescribing a medication. I said: 'in this case I think you should refer the child to a pediatrician because it is something really specific". He wanted to prescribe carbamazepine. In this case I think it's better to have a specialist. So he referred the child. We have this nice partnership in which we work together, discuss some cases. Then she went there, the physician referred the case to a psychologist. And we observed, I asked the agent to observe this family because it was a family very new in this field, and I wanted the agent to pay greater attention. (E2).*

Communication among the team's members has as a goal a better assessmentof the child's condition and that of the family and to enable decision-making that leads to more appropriate practice.

One matter that draws attention is the understanding of professionals regarding the need to use the resources available to protect the health and wellbeing of the assisted families, whenever they are necessary and needed in a timely manner.

> *The vaccination room is currently upstairs and the outpatient is separated, you know. I make a link with the vaccination. The nursing technician from the neighborhood's vaccination room refers those missing vaccines to me. So, I take the opportunity and tell [to the CHA] 'Take a look at the card and see whether the weight is correct.' (E1)*

> *Now, the nutritionist and I exchange emails and we are reachinga consensus that may she [the child receiving treatment] is not gaining too much weight because of her genetics. The mother is really tiny and skinny though the father notso much. And underweight children are generally despondent, have ugly hair, and this girl is beautiful, smart, talkative, very active. But we keep an eye on her because the mother doesn't care much.*

Communication among the PHC services enables the complementation of actions, making them more effective and more likely to definitively resolve problems with a practice that avoids an equivocal understanding that referring a patient means transferring responsibility.

The work with effective communication among the health services enables the continuity of care. Other sectors also reported thus, emphasizing a closer communication, either in person, by telephone or through reports:

> *Santa Casa always supports our pregnancy course. All the pregnant women attending the course go to Santa Casa for the pre-partum and see where labor takes place, how it works, the rooming-in, what they have to take to maternity and what they don't. (E12)*

> *SWRC and SWSRC were great also. We sat down and the girls made a report. I took my motorcycle and went straight to SWSRC, in person, because you can't make calls in theunit, but I have their number in my mobile. FHSC is now helping a lot, getting their hands dirty. We have a folder to sent reports of patients to them. Two folders, one goes and another comes and*

> *goes. Then I make the report and go there personally. Then she herself gets in touch with the personnel from SWSRC. FHSC is taking care of what was static here. (E1)*

> *When we identify there's a small risk for a child, a minimum risk, I pass the case to the social worker to assess. 'Listen, go there and assess the situation, the family's context.' Our going there [an area with poor living conditions and hazards] is complicated because people do not always accept it well. You go there to consult again and she mightthink you want to turn her in, to harm her in some way. And it's not that. So in these cases, it's essential that we have a partnership with social services. (E9)*

The professionals from the Social Work Referral Center (SWRC), the Social Work Specialized Referral Center (SWSRC) and the Family Health Support Center (FHSC) strongly support the family health staff. The support each team receives and offers in a search for ways to defend children's quality of life is very important.

Gaps in the relationships of partnership among the professionals integrating the city services network

There are situations showing the need to strengthen the relationships among professionals from different services. This fragmentation in professional relationships can result in a greater vulnerability for children, since their needs are no longer integrally met.

> *Sometimes they expose us, especially the SWSRC. This is the greatest difficulty. There were two cases we didn't report mainly because of this. We'll get exposed and the situation gets complicated. [...] We kind of have our hands tied when we face some situations. Because, unfortunately, what we see in practice is that, sometimes, the social work aspect doesn't function. Sometimes, the nurses themselves have to fight, call the guardian council. The council, in turn, is sometimes unprepared, doesn't know what to do. So, we are kind of on our own. (E2)*

> *When we needed something, the Guardian Council was the most difficult.(E13)*

The professionals or services need to know how to maintain confidentiality concerning the involvement of one another in a case. It is especially relevant for the FHS, given the need to maintain bonds with families. Poorly handled situations may expose the staff, which in turn, may choose not to cooperate within a partnership, a situation that could possibly even increase the vulnerability of children.

Interactions among various sectors are often dissonant; information does not flow and the services do not seek a joint solution.

> *I've already seen a child with a bump this size, the mother had a mental disorder, I called the police, called the guardian council, reported it in the occurrence book, everything. But then we got nothing back, no counter reference, we don't know what happened, we only know about it because we go to the patient's home. (E1)*

This is an important gap that may violate the guarantee of a child's rights. These are cases in which the Guardian Council needs to intervene and, therefore, are more complex cases involving aspects the health staff cannot take care of by itself. The Guardian Council is the official reference in these cases and its weak performance aggravates the situations of vulnerability experienced by children and families.

The mechanisms of counter reference and inter-institutional communication are not effectively put into practice, hindering the expansion of healthcare services and possibly leading to violations.

> *There were cases we had to report to the Guardian Council, but there was no counter reference; we had to keep calling back to find out something about it. 'Oh, what happened?' 'What was the procedure with this family?' They wouldn't discuss with us so we could work together. (E11)*

> *I guess we need to improve communication among the sectors, work with inter-sector cooperation so that we try to seek mechanisms to help these families. These families are already sick, because it is not only an individual but the whole family. So I guess we need to gather everyone, we could try to seek mechanisms to help these families change their situation. Even the Pastoral da Saúde [Pastoral Commission for health] could be a good ally, the Pastoral da Criança [Pastoral Care for children]. I guess we have to seek partnerships in the community, as well. (E2)*

These practices can be mutually strengthened if the need for a more cooperative network with systematized support including non-governmental actions is taken into account.

It is desirable that an organized network should have consolidated information on access to all existing governmental and non-governmental services that would be used to facilitate communication among the teams, as well as to guide the population to seek these services. This is relevant and can enhance the advocacy role implemented in the services' daily practices. This type of information does not seem to be availablein an organized manner.

> *I say: 'Listen, there are lawyers from the university [from a project of the Law program that serves the population pro bono], did you know about them?' 'It works during these and those hours.' I even had a schedule here because the trainees came and hung it. But that's all I know. Because certain things we know and others we have no idea. (E1)*

The dissemination of relevant information about the existing services in the city is important to show more clearly the resources available to citizens to aid the exercise of their rights.

Limitations on the integrality and inter-sector cooperation of actions

The interviews show there are limitations in the work process used in cases that require integrative actions from the family health staff. The main origins of the difficulties found are organizational, structural and managerial issues, going through conceptions and attitudes that are consolidated among professionals that are based on their understanding of networks.

> *We see that the FHS is the entry door and is also the exit door. It's like, it goes and comes back to the FHS. We have to be accountable for everything. When it comes to a hospitalization, the hospital's social worker wants to know what happened and calls us: 'What was the FHSdoing?' 'Well guys, weren't you monitoring this case?' So, we have to be accountable, nobody else is accountable, nobody gives support, everyone only wants the FHS to deal with it. Why does everybody think that the patient is only a responsibility of the FHS? They don't understand that the patient is ours, is mine and yours, too. [...] We sat together with the FHSC and I said: 'I'm going to talk with CAPS to see what support they can provide.' Because it's not just one person in the family who has problems, it starts with the grandfather, affects the granddaughters, the child's mother and everyone. Then the CAPS' coordinator said she couldn't do anything. When we contacted her she said that the only thing I could do was to call the Guardian Council to take the child. I said: 'No, but that is not the idea.' So, as my objective, I wanted an assessment by the CAPS, to see what we could do for the family, to support it. I tried twice with no success. (E2)*

This lack of co-responsibility among services draws attention because it hinders the monitoring, initiated by the family health staff, of cases of managerial difficulty in which the only certainty that seems to prevail is that it is a problem under the FHS's responsibility. This context reduces the possibilityof resolving the case within the FHS sphere and ultimately violates the patients' right to health, an important issue to be discussed by the professionals and managers of the city health system.

A similar situation is reported below:

> *But the problem was not her, the problem is what she has. She has a mental disorder and the doctor referred her to the mental health department, but the mental health personnel said she is normal. Ah, but she does have some problem! If you see her, you can tell. The doctor puther ICD as being Munchausen's Syndrome, meaning that the mother involuntarily wants to hurt the child. But then, this syndrome, the people from the mental health say she doesn't have it. But don't investigate other disorders, either, you see? The FHSC went there also. Her daughter is one year and five months old and is underweight. The nutritionist went there, too, and I have her chart here; it is alarming. (E7)*

> *I think the SWRC should be more active because they are better prepared to deal with these social issues; they are social workers; they can go to people's homes, talk, and have a differentiated approach, because we do what we can. And we have to preserve the bonds established with the FHS. If suddenly we take a more drastic attitude, including the district attorney and all these, then the family no longer comes to the unit, looses trust. Even the social worker from the FHSC mentioned that cooperation has been difficult because they sometimes refer the case to the SWRC to make a visit and the papers stay there; it takes time. And I don't know if it is because of a lack of professionals. (E12)*

It is apparent that mental health is an area in which the FHS staff needs support and also needs an efficient referral and counter referral system. A routine where there is fluid communication among the teams, the FHS and the Psychosocial Support Center (CAPS) can result in a process of primary health qualification to better deal with cases of mental disease, strengthening both services.

In the flow of information within the city system, the resolution of cases that were initially approached by a service may be hindered due to points where care is discontinued, negatively impacting the results of advocacy initiated by the initial service in its work process.

This limitation also exists in the work performed by the Guardian Council, which inspires fear and concern:

> *There are no working conditions in the Guardian Council, even in terms of physical structure; there is no individual room to use to approach the patients privately. We experience this, the system is very neglectful. I think that we could have a better partnership with the Guardian Council, know the people, have a talk or a meeting with them. I found out the phone number with a phone call I made, I didn't even know where the Guardian Council was. There is no communication. I'm talking about rights, the legal field, really. With the police, too; why not? Guidance about how I should approach the case of a child that I suspect has been raped. The content that we receive in college about it is very limited and it doesn't help, only when you start working do you develop a notion about these situations. Other sectors are better prepared and can teach us. (E1)*

> *Today everything is about lawsuits, so I'm terrified. Even though I consider calling the Council, I'm afraid because there are families that you don't know whether anyone has a gun. We work in an isolated area, with no security. We have experienced difficult situations and nobody gave any advice, or helped us. So, what is lacking most is safety to deal with these cases. Even if there are other services working on the case, the case is initially reported by the FHS and the family knows that. How can I call the Guardian Council? The family only comes here. The entry door to the system is here. And sometimes, within the network itself, the professionals are not careful to avoid exposing the FHS. (E7)*

The limitations concerning the Guardian Council's work are related, among other factors, to a lack of requirements on the composition and operation of this service compatible with its complexity and the importance of cases where the rights of children are violated, who are individuals incapable of satisfactorily acting in their own defense.

There is an understanding that the limitations manifested in the work performed by the Guardian Council are a result of structural issues, lack of investment in physical structure and technical qualification, which suggests an absence of local management in the role performed by this service, that of protecting the rights of children. There is also a certain marginalization of the Council within the city services network when the nurse notes there is no information in the unit on how to access this service. One nurse identifies a potential to contribute to the work process of formal and programed mechanisms to communicate with the Guardian Council and other services, such as the police, grasping what it means for health professionals to be better prepared to deal with delicate issues, for which they have received no specific education but which are common in their work routine.

The following testimony has suggestions that could be part of a set of actions aimed to provide greater support to teams and families:

> *A lawyer would work as a reference within the FHS. She would provide administrative support to the employees in the situations of families. How interesting. She would be a person to support us and help the social workers, as well, a link to many things. To ease or clarify doubts, we would have more possibilities of action. Because sometimes, it is so difficult having someone to guide us that we'd rather not act. I understand that this guidance would enable us to be more active. Because whatever we need, we have to go to the building [city hall] and talk. If you have to clarify a doubt, it has to be with him, the city hall attorney. Why will he solve our problems here? And he doesn't understand anything about health. He guesses. If there's someone from the health field, the person will get prepared, involved. The person will get engaged, committed. This lawyer could enter the FHSC. (E5)*

An understanding regarding the complexity of the work performed within the FHS, as well as the need to expand its structure, expanding the support network to professionals in other fields, going beyond the health field and including the law field, is a more comprehensive way to look at integrality of care provided to families.

Additionally, accomplished rights need to be exercised, since these rights were not accomplished in a passive way and, in general, the way things happen in Brazil does not favor this active exercise for there is a lack of preparation and culture for that.

> *A proposal that came to us and that I found interesting is to start meetings in macro areas. People from education, the schools' principals, will participate so we can try to make inter-sector cooperation a reality,*

because we're having difficulties, we're working in isolation and getting nowhere. The State started with this ideaand passed it to the city through the organization of a master plan. Now, the suggestion is that we meet in macro areas, like the area of the sanitary district territory. Then the territory is the same here, we are part of downtown, the neighborhood BH and NSG, which are close. So, you put together the nearby areas. Then there is the FHS, the School, the FHS from Novo Horizonte, the FHS from Nossa Senhora das Graças and the Novo Horizonte outpatient. The health services, education services, SWSRC, SWRC. Then, the FHS coordination holds a monthly meeting with each macro area. So we sit together to see what we can do together. We'll organize it to invite the school' principals [...] let's see whether they will participate. This is the proposal, but we haven't had any meetings yet." (E2)

The proposal symbolizes an important step, which results from an acknowledgment of the need to establish formal mechanisms of communication and interaction among services. The operationalization of the next steps that will involve contacts, planning and meetings will require clarity and persistence on the part of the organizers to avoid fragmentation of work processes. The formalization of this communication and approach to existing difficulties and those that will emerge among services is necessary and urgent so that the State, managers and professionals can comply with their ethical commitment to provide integrated, definitive and quality actions, which is a right of the population.

DISCUSSION

Working with the family health proposal and with a broadened conception of health involves dealing with social issues, complex and difficult situations, in which the isolated work of health professionals does not lead to a significant impact, while partnership and networking are essential.

Among the difficulties experienced by nurses, there were reports of fragility in the relationship of accountability among services and in the communication process, a lack of physical structure and technical qualification of some teams and low problem-solving capacity in some services, hindering the continuity of actions initiated by the FHS.

With the possibility to exercise the human right to health in different points in time, the SUS represents a considerable accomplishment for Brazilian society. Nonetheless, the low problem-solving capacity of some services, cases in which quality of care is low and there is violation of human rights, shows the need to provide the population with a more structured organization of health services with a focus on integral care[9].

Many situations illustrated in this study contain elements that are contrary to the National Policy of Humanization of Care and Management of the Unified Health System, named HumanizaSUS. This policy recommends humanization, such as the valorization of different participants in the process in which health is produced, including not only users, but also workers and managers, as well as the mutual commitment among the agents involved in the health practices, with co-responsibility based on the establishment of supportive bonds and of cooperative networks in the work process[10].

In the context of services available, the SWRC and SWSRC are units in the social work service that have family-centered care in common with the FHS. Such a common goal favors and strengthens the possibility of partnerships among these services. The FHSC is represented by a team of professionals who work in diverse fields of knowledge who should construct practices together with the members of the family health staff in the face of problems identified in the covered area[11]. It is worth considering the importance of a support matrix, which requires a change in the operating logic of the city's services network as a method complementary to the hierarchical system of referral and counter referral, including more active and fluid communication through which responsibilities can be shared.

In general, health professionals are not prepared to deal with situations that involve violence against children and experience difficulties related to cultural, ethical and legal aspects[12]. If, however, these professionals are imbued with abilities to observe and intervene, they have the potential to protect and put human rights into practice[8-13].

We note that preventing and dealing with cases of child violence is one of the many tasks of the FHS, so that initiatives of continuing education in this direction, as well as the qualification of institutions that protect children and the expansion of support networks to aid these teams, can contribute to reducing the insecurity of professionals, which will result in a reduction of unreported cases of abuse[14].

The defense of children's health encompasses multiple factors, such an ample understanding of the health-disease continuum and the social determinants of this process. Therefore, it is imperative that health professionals who are consciously advocating the health of those to whom they provide care develop a process of communication to establish partnerships with other sectors, as well as resources within the community itself, valuing both governmental and non-governmental services[4].

Hence, the impact of the actions performed by the family health team concerning the quality of life of users directly depends on their capacity to work together in a network of professionals and services[15].

Another aspect to note is that the incorporation of mental health care by the family health teams has been slow in implementation and is often harmed by the limitations of the services that specialize in mental health, both in terms of quantity and quality, leading to a lack of cooperation among services due to unsatisfactory mechanisms of communication among the teams[16].

Many laws, especially the Child and Adolescent Statute, were established to enable the intervention of the State in situations of child abuse. Nonetheless, these measures of protection will only be applied when the silence that surrounds intra-family violence against children is broken[17]. Negligence is contrary to Article 13 of the Statute, which states that cases where there is a suspicion or confirmation of child abuse, it must be reported to the Guardian Council, notwithstanding other legal provisions[18].

The reporting of child abuse, however, is not part of the work performed by the FHS professionals. One study reports that 55.6% of its participants identified child abuse in the context of the family health work and did not report the cases[14].

An important challenge in the practice of the family health teams is in the composition of the care network with other services existing in delimitated territories, the so-called Territories Integrated inHealth Care, which should be composed of principles like the existence of a defined area with its respective population, healthcare coordinated by the PHC and integration with other healthcare services with the purpose of producing and encouraging inter-sector actions among the diverse social policies with a focus on health. This proposal should be grounded on the strengthening of primary healthcare and on the concept of inter-sector cooperation[11].

Healthcare involves decisions on which things can and should be done, referring to the construction of knowledge and practices with new dimensions for a kind of care that respects, protects and puts into practice the rights of citizens[8], founded on a dialogical base grounded on the knowledge and values of the different stakeholders[6]. Given this conjecture, we should note the singular role nurses play in the sphere of the right to health and life[9].

Partnerships with services such as housing, sports, culture, leisure and security were not mentioned in this study, which shows there are many challenges in the establishment of inter-sector cooperation in the city's dynamics.

FINAL CONSIDERATIONS

This study's results show that there are positive and negative partnerships in situations of care and the defense of child health in which fragmentation of relationships among professionals and services harms the continuity and/or resolution of actions initiated in the FHS context, leaving children and families more vulnerable.

Nursing care is relevant for the defense of children rights, supporting healthcare provided to the child and family in the FHS sphere within the SUS. In the search for a broadened approach to providing integral care and meeting the demands identified by nurses, it is necessary to value communication among professionals and services and construct perspectives of work that avoid gaps in relationships of partnership, in addition to expanding integrality and inter-sector cooperation in the network of actions. In this context, a support matrix is an important tool in the management of health services, requiring changes in inter-disciplinary relationships so that professionals from specialized services work together with teams that require technical support.

Inter-sector cooperation allows the expansion of health actions, while management strategies are essential to consolidating the integrality of actions and services, especially given the set of laws and programs designedto achieve the integral protection of children. In this sense, the expansion of advocacy actions in health is important, acknowledging health as a right and seeking to guarantee it by strengthening joint actions and cooperative mechanisms that favor it.

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