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RESEARCH

Desafios para aplicação da estratégia de atenção integrada às doenças prevalentes na infância

Challenges implementation of the integrated attention to childhood illness

Desafíos para la aplicación de la atención integral de las enfermidades prevalentes de la infancia

Ingrid Leticia Fernandes dos Santos [1], Maria Aparecida Munhoz Gaiva [2]

ABSTRACT

Objective: to analyze the advantages and difficulties faced by professionals working in the family health strategy cuiabá / mt for the application based integrated management of childhood illnesses (imci). **Method:** exploratory descriptive study quantitative approach with 101 professionals working in family health units. with data collected from march to may 2013, a questionnaire applied to professional and systematic observation of the health unit. **Results:** the main difficulties pointed out by professionals in implementing the strategy were the lack of training of the staff members (31.0 %) and prescription drug protocols for nurses (23.4 %). the facility that stood out was the link with the enrolled population (30.3 %). **Conclusions:** the results boost the reflection of practice for professionals responsible for childcare as well as managers should support the implementation of this important strategy for health care for the child.**Descriptors:** AIDPI; primary health care; child health; family health.

RESUMO

Objetivo: Analisar as facilidades e dificuldades enfrentadas pelos profissionais que atuam na estratégia saúde da família de Cuiabá/MT para aplicação da estratégia Atenção Integrada às Doenças Prevalentes na Infância (AIDPI). **Método:** Estudo descritivo exploratório de abordagem quantitativa com 101 profissionais atuantes em unidades de saúde da família. Os dados foram coletados de março a maio de 2013, por meio de questionário aplicado aos profissionais e observação sistemática da unidade de saúde. **Resultados:** As principais dificuldades apontadas pelos profissionais na aplicação da estratégia foram a falta de capacitação dos membros da equipe (31,0%) e de protocolos de prescrição de medicamentos para enfermeiros (23,4%). A facilidade que mais se destacou foi o vínculo com a população adscrita (30,3%). **Conclusões:** Os resultados impulsionam a reflexão da prática dos profissionais responsáveis pelo atendimento à criança, bem como dos gestores que deveriam apoiar a aplicação desta importante estratégia de atenção à saúde da criança. **Descritores:** AIDPI; Atenção Primária à Saúde; Saúde da Criança; Saúde da Família

RESUMEN

Objetivo: analizar las ventajas y las dificultades que enfrentan los profesionales que trabajan en la estrategia de salud de la familia cuiabá / mt para la aplicación basada en la gestión integrada de las enfermedades de la infancia (aiepi). **Método:** estudio descriptivo exploratorio con abordaje cuantitativo con 101 profesionales que trabajan en las unidades de salud de la familia. con los datos recogidos entre marzo y mayo de 2013, se aplicó un cuestionario a la observación profesional y sistemática de la unidad de salud. **Resultados:** las principales dificultades señaladas por los profesionales en la aplicación de la estrategia eran la falta de capacitación de los miembros del personal (31,0 %) y los protocolos de los medicamentos recetados a los enfermeros (23,4 %). la instalación que se destacó fue el vínculo con la población inscrita (30,3 %). **Conclusiones:** los resultados impulsar la reflexión de la práctica de los profesionales encargados de la atención del niño, así como los gerentes deben apoyar la aplicación de esta importante estrategia para la atención de salud para el niño.**Descriptores:** AIDPI; atención primaria de salud; salud del niño; salud de la familia.

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INTRODUCTION

It is estimated that about 400 thousand children residing in the Americas die before completing five years of age, and more than half (65 percent) of these deaths are related to factors that hamper the control of diseases most prevalent in childhood, such as inadequate conditions of life, lack of knowledge about the severity of the disease and the treatments on the part of the caregiver.[1]

Faced with this situation, the World Health Organization (who), Pan American Health Organization (PAHO) and the United Nations Children's Fund (UNICEF), created in 1994, the strategy of integrated management of childhood illness (IMCI), with the aim of reducing the mortality of children under five, especially those caused by the prevalent diseases and preventable; shorten the episodes and severity of infectious diseases and ensure quality comprehensive care to children under five years in health services and in households.[1] In Brazil, the strategy introduced officially in 1996, to apply by doctors and nurses of the family health units (FHS).

The changes promoted by the child health strategy were noticeable in Brazil and in other countries that adopted her. In Benin, Morocco and Bangladesh had sensitive improvements in health indicators, infant mortality, and hospitalization of children, in addressing the symptoms, rational use of medicines and on the actions of health promotion and prevention of diseases.[2,3] In Bangladesh, randomized trial that compared the health indicators of areas where IMCI was implemented with areas that wasn't, pointed out that the infant mortality rate was 13.4% lower in regions where the professionals applied to those not strategy occurred.[4] In addition, the evaluation and monitoring process of IMCI results showed that countries have faced financial

problems and lack of supervisors trained to assess your application and implementation.[7]

Despite the importance shown by studies that evaluated the IMCI, the deployment processes and implementation of the strategy in Brazil face great challenges as partiality of application, differing opinions about the effectiveness of same, lack of political support, frequent changes of the professionals of health teams and lack of trained facilitators to promote the courses. [5,6]

The availability of material resources is also considered one of the challenges for implementation of IMCI, since in certain regions, the essential elements, often are not available in the health units.[7] The Health Ministry recommends that, for the full implementation of IMCI, besides professionals, each unit must have minimally of some medicines, all vaccines basic infant immunization calendar, infrastructure, equipment, and inputs for the development of the strategy.

So, for the deployment and implementation of IMCI to happen it is necessary to conduct trainings to improve the skills of professionals, improving community health practices with health education, decentralization of services and strengthening of health systems, maintaining the professional units and adequate resources for its implementation.[1]

In this context, this study aimed to analyze advantages and difficulties faced those health professionals of Cuiabá-MT face in the implementation of IMCI.

METHOD

Exploratory research descriptive quantitative approach, which included the participation of professional, being 51 101 nurses and 50 doctors, crowded in 58 family health units (USF) in Cuiabá/MT, the municipality has a total population of 551,098 inhabitants, being that of these, it is estimated that 49,818 are children under five

years of age.[8] The network of primary health care in the municipality counts with 22 and 63 health centers family health teams, divided into four administrative regions. The study developed at USF, because in Brazil, the strategy defined to apply preferentially by family health teams.

In Cuiaba, the USF, mostly, shared by two teams, composed a doctor, nurse, Assistant/technician nursing and community health agents (ACS). These units linked to the coordination of primary health care in the municipality, which is composed of a multidisciplinary team responsible for planning and evaluation of the actions undertaken.

To obtain the data we used two instruments: questionnaire and systematic observation of the health unit. The questionnaire, with closed and open questions, was applied to doctors and nurses, to plot the profile of these professionals, as well as to seize the difficulties and facilities found in the daily life of work for the implementation of IMCI. Whereas studies that evaluate the IMCI point the lack of resources as one of the difficulties for its effective application, held also the systematic observation units rank the availability of essential resources to develop it.

The data collection occurred between the months of March and May of 2013 and conducted by researcher and graduate students in nursing, specially trained for the application of questionnaires and observation of units.

The resources available for implementation of IMCI were classified in appropriate or inappropriate, taking as a reference the criteria of evaluation of the IMCI of the Ministry of health (MS), which establishes the essential components for your application and the divides in the following groups: infrastructure, equipment, drugs, vaccines, supplies and printed. Considered appropriate the groups in which essential elements were available on unit or were part of the routine service. The groups in which any essential item was not part of the routine of service were rated as inadequate.[9]

So were considered essential at least one type of oral antibiotic, analgesic/antipyretic, iron, anthelmintic, brocodilatador, oral rehydration serum

(item medicines), all vaccines basic calendar of vaccination (vaccine item), scales, thermometer, cloth or gauze to Wicks, jar, Cup and spoon (equipment and supplies), location for conducting intravenous and oral rehydration (infrastructure), service forms of IMCI, child health handbook and manual of procedures of IMCI (printed).[9]

The data processed with the capabilities of the EPI-Info statistical software in version 3.5.2. For analysis, we used the simple statistics (frequency and proportion of answers) and for best viewing, the results presented in tables.

This study approved by ethics in Research Committee under the opinion paragraph 194, 315.

RESULTS AND DISCUSSION

The data showed that most of the studied population was female (69.3%) and had a degree in nursing (50.5 percent). As for the time of training, 32.7% graduated between 3 and 5 years. As regards graduate, 70.3% had a post-graduate lato sensu, being 41.6% in the area of family health. As regards the time of performance in ESF, 1/3 of the professionals served between 3 to 5 years (table 1)

Table 1 -Profile of nurses and doctors studied. Cuiabá Mato Grosso, Brazil, 2013

Personal and professional data	n	%
Sex		
Female	70	69.3
Male	31	30.7
Graduation		

Nursing	51	50.5
Medicine	50	49.5
Time of graduation		
3 to 5 years	33	32.7
6 to 10 years	27	26.7
Above 10 years	26	25.7
1 to 2 years	9	8.9
Less than 1 year	6	5.9
Lato sensu graduate studies		
Yes	71	70.3
No	24	23.8
Progress	6	5.9
Postgraduate area		
Family health	32	41.6
Other	28	36.3
Public health	15	19.5
Child health	2	2.6
Time of performance in ESF		
3 to 5 years	30	29.7
1 to 2 years	24	23.8
6 to 10 years	19	18.8
Less than 1 year	15	14.9
Above 10 years	13	12.9

The main difficulties pointed out by professionals to apply the IMCI were lack of staff training (31.0%) lack prescription drug Protocol for nurses in the city (23.4%) and lack of adequate infrastructure (15.8 percent). Among facilities highlighted the link with the adscrita population (30.3%) and efficaciousness of attendances (21.2

percent). As the opinion of professionals about the IMCI, 44.6% evaluated it as good (table 2).

Table 2 - Difficulty, amenities, and views of professionals on the implementation integrated management of childhood. Cuiabá - Mato Grosso, Brazil, 2013.

Variables	n	%
Difficulties in the implementation of IMCI		
Lack of training for team members	53	31.0
Lack of prescription drug protocols for nurses	40	23.4
Inadequate infrastructure	27	15.8
Can't answer	18	10.5
Lack of medicines	13	7.6
Service demand beyond the capacity of the unit	12	7.0
Lack of printed	3	1.8
Facilities for the implementation of IMCI		
Life link adscrita population	50	30.3
Efficaciousness of attendances	35	21.2
Can't answer	28	17.0
Completeness of the actions	23	13.9
Health education	20	12.1
Opinion on the IMCI strategy		
Very good	27	26.7
Good	45	44.6
Don't know	26	25.7
Regular	3	3.0

As the classification of the availability of resources for the implementation of IMCI in Cuiaba, the item classified as appropriate vaccines in all USF and printed as inadequate in 100% units. In relation to the Group of medicines and essential infrastructure for the implementation of IMCI, 50% of the units classified as appropriate. Equipment inadequate in 74.1% units (Table 3).

Table 3 - Classification availability resources implementation integrated management childhood. Cuiabá, Mato Grosso, Brazil, 2013

Resources/inputs	Suitable		Inappropriate	
	n	%	n	%
Medicines	29	50.0	29	50.0
Vaccines	58	100.0	-	-
Equipment	15	25.9	43	74.1
Infrastructure	29	50.0	29	50.0
Printed	-	-	58	100.0

The predominance of female professionals in the family health strategy (FHS) is a feature of the primary care workforce in many Brazilian States. Research that outlined the demographic and occupational profile of the ESF professionals State of Mato Grosso showed that 59% of workers were female.[10] A similar result was found in Montes Claros/MG and Anápolis/GO.[11-12]

Another feature of the profile of the professionals of the present study was the relatively short time of training. Research that analyzed the top-level professional profile of the family health strategy of Anápolis/GO, also pointed out this feature, since 52% of doctors and nurses were graduates for less than five years.[12] Shorter also noted in the survey that assessed the implementation of IMCI in Russas/CE, where 58% of the doctors and 29% of nurses who acted on ESF formed less than a year ago.[13]

The recent training time can contribute to the consolidation of strategies of attention on family health, including IMCI,[14] since the school curricula in healthcare come suffering changes and seeking a more general training, which enables the student to develop skills and expertise needed to intervene in various aspects of health-disease process, both within individual in collective. In addition, IMCI has been offered as a basic content in undergraduate courses of medicine and nursing in Brazil for more than 15 years.[6]

Graduate search by health professionals is a reality present in the country. In Anápolis/GO and Montes Claros/MG, most professionals had some graduate *lato sensu*,[12,11] just like in this research and study in Mato Grosso in 2000.[10] The significant numbers of professionals who have sought evidence of interest in specializations ensure scientific support to get the job done in the ESF. In addition, this profile shows commitment to professional performance and can understood as a way of keeping the job, due to the instability of employment in healthcare links.

The choice by specializations in the area of public health and family health indicates a sanitarian profile of professionals working in the ESF in Cuiabá/MT, similar to that found in Anápolis, Goiás.[12] In turn, the Russian studies/CE and in the State of Mato Grosso, showed smaller percentages of professionals with expertise in these areas, 33% and 32.8% respectively.[13,10]

As regards the time of activity of the professional persons within the ESF, the results showed that 1/3 of them played between three to five years, a percentage similar to the training time, which indicates that these began his professional activities as soon as completed graduation. Research that has assessed the

implementation of IMCI in Russas/EC, showed that the professionals operating in ESF for less than a year.[13] It is important to note that a short time of performance in ESF can compromise the development of the work and the establishment of ties with the community, which in the case of a child is critical to the family's adherence to the monitoring of child health.

The link consists in building relations of trust and affection between healthcare professionals and the community, allowing for deepening the process of shared responsibility for health over time.[15] In this sense, one can consider that the role of the professional in the family health team is essential to the success of the actions developed in the framework of primary health care as the IMCI.

The quality and success of the implementation of any health care strategy directly related to the profile of professionals. In the case of IMCI, one of the biggest difficulties for its consolidation is the shortage of workers that meet the requirements to serve on the new model of health care.[13]

Study which identified the challenges to implementation of IMCI in 27 countries, including Brazil, highlighted as one of the main difficulties the lack of training for the entire staff of the unit.[7] In the Brazilian reality, this situation may related to lack of political and financial support and the high turnover of professionals working in the ESF. It is important to note that the training of human resources for the implementation of IMCI is one of the three pillars that underlie the strategy and its absence can generate fragilities in the knowledge of the professionals on the same and on its application.[16]

Unlike the difficulties pointed out by the professionals of the present research, qualitative study with doctor if nurses held previously in Cuiaba, highlighted as the main obstacle to implementation of IMCI, the excessive demand of attendances and inadequate physical structure.[17]

The lack of protocols for prescribing medicines for nurses was also evidenced in research that has examined the practices this professional in the IMCI.[16] It is emphasized that in this study, this aspect was mentioned both by nurses as by doctors.

Prescription medicines for primary care nurses is not well accepted in the city of Cuiabá and other cities of the country.[16-17] This situation indicates unfamiliarity on the part of the professionals of the tasks of the members of the multidisciplinary team of ESF National Policy as defined by the basic attention, [18] as well as the laws governing the exercise of the various health professions in the country.

With respect to prescription medication, the nursing professional practice law defines in its article 11 as "private activity of nurses as health team member, the prescription of medicines in public health programs established and approved by the health institution routine".[19] Therefore, the nurse, as a member of the health team, has the right and duty to exercise their professional autonomy, including prescribing drugs that are part of the assistance protocols, such as IMCI.

Worth pointing out that, the Municipal Health Secretariat of Cuiabá has specific regulations, which provides for the prescription by nurses. According to Ordinance No. 103 of 3 September 1998, the nurses are backed up legally prescribe medicines in public health programs established during the nursing consultation, when invested in capacity and function within the framework of the Health Foundation of Cuiabá.[20] In this way, it becomes clear that there is no legal impediment in Cuiaba for this exercise, especially for the implementation of IMCI, since the said Ordinance includes the list of medications whose prescription allowed to nurses of the municipality and includes all the medicines recommended by the strategy. It is important to note that the implementation of IMCI is not restricted only to prescription drugs, especially because the educational component is a fundamental part for the success of the same.

Health education is the third pillar of IMCI, besides being an action inherent in the practice of the professionals working in the ESF. In the context of the performance of nursing, health education is an instrument that facilitates interaction between nurse, family, and community. In this perspective, the educational activities should be sustained in the reality of individuals, favoring the development of individual and collective awareness in order to rethink beliefs, practices and values in health, to

promote the autonomy and the construction of citizenship.[1] Therefore, the educational process can understood not only as content transmission.

Thus, to the health educational process be effective in any population, including the children, it is necessary to know the context of the lives of individuals, as well as their susceptibilities and potential so that you can adapt to your needs and educational actions previous knowledge.[21]

The main facility pointed to by the participants of the present study was the creation of life link adscrita population. The establishment of the link promotes the quality of education in health advocated for IMCI, promoting family and professional involvement in identifying and solving the problems of health of children under five years. The territorialization and the creation of ties are key to the success of the strategies implemented in the context of family health, as is the case of IMCI. The link provides in addition to the user with your health co-responsibility, developing practices based on prevention of diseases and health promotion.[15]

As for medicines available for the implementation of IMCI, the result found in Cuiabá is unlike any seen in Russian/EC, who owned 80% of equipment and 100% of medicines recommended for the development of the strategy[13] as regards vaccines, the findings of the present study were similar to those found in research that has assessed the physical structure of basic health units for child care in Cuiabá, MT.[22]

The fact that no unit searched have available the forms necessary for the application of IMCI, and only 2% of professionals mention this aspect one of the difficulties for its implementation, indicating little appreciation of the strategy both on the part of managers as professionals themselves.

CONCLUSION

Although study participants assess the IMCI strategy as good for the assistance of children younger than five years, they pointed out several difficulties for your application. According to professionals, the main challenges for its implementation are located in the processes of permanent education, evidenced by the lack of training for all team members, in professional practice, with the absence of protocols for prescribing medicines for nurses, and by the scarcity of essential resources for implementation of IMCI in the units.

In this way, the results boost reflection of practice of professionals responsible for childcare, as well as the managers who should support the implementation of this important strategy for health care of the child.

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