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SAÚDE DA CRIANÇA NA ATENÇÃO PRIMÁRIA: EVOLUÇÃO DAS POLÍTICAS BRASILEIRAS E A ATUAÇÃO DO ENFERMEIRO

CHILD HEALTH IN PRIMARY CARE: EVOLUTION OF BRAZILIAN POLICIES AND NURSES' PERFORMANCE

SALUD DEL NIÑO EN LA ATENCIÓN PRIMARIA: EVOLUCIÓN DE LAS POLÍTICAS BRASILEÑAS Y LA ACCIÓN DEL ENFERMERO

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RESUMO

Objetivos: Descrever o processo de construção histórica das políticas de atenção à saúde da criança no Brasil, a participação da enfermagem nesse processo e os avanços e desafios atuais para a atenção primária à saúde. **Método:** Trata-se de um artigo de reflexão teórica. **Resultados:** A atenção à saúde da criança no Brasil passou por um extenso processo de evolução e qualificação no âmbito das políticas públicas, o que resultou em avanços na redução da mortalidade infantil e da desnutrição e na ampliação da cobertura vacinal. Os atuais desafios – a mortalidade neonatal e a obesidade – estão elencados na atual diretriz programática brasileira e também nos objetivos do Desenvolvimento Sustentável. O enfermeiro destacou-se como um profissional com participação efetiva e fundamental na atenção à saúde da criança, mesmo antes da consolidação do SUS e da promulgação da lei do exercício profissional. **Conclusão:** Para superar as lacunas entre as diretrizes programáticas e a capilaridade dessas políticas na realidade dos serviços de saúde, torna-se necessária a consolidação da presença e extensão dos atributos da APS nos serviços de saúde brasileiros.

Descritores: Saúde da criança; Atenção primária a saúde; Políticas públicas; Enfermagem.

ABSTRACT

Objectives: To describe the process of the historical construction of Brazilian child health care policies, the participation of nursing in this process and the current advances and challenges for primary health care**. Method:** This is an article of theoretical reflection**. Results:** Child health care in Brazil underwent an extensive process of evolution and qualification in the scope of public policies, which resulted in advances in the reduction of infant mortality and malnutrition and in the vaccination coverage expansion. The current challenges - neonatal mortality and obesity - are listed in the current Brazilian programmatic guideline and in the Sustainable Development objectives. The nurse stood out as a professional with effective and fundamental role in the child health care, even before the consolidation of the UHS and the enactment of the professional practice law. **Conclusion:** In order to overcome the gaps between the programmatic guidelines and the capillarity of these policies in the reality of the health services, the presence and extension of the PHC attributes in the Brazilian health services need to be consolidated.

Descriptors: Child health; Primary health care; Public policies; Nursing.

RESUMEN

Objetivos: Describir el proceso de construcción histórica de las políticas de atención a la salud del niño en Brasil, la participación de la enfermería en ese proceso y los avances y desafíos actuales para la atención primaria a la salud**. Método:** Se trata de un artículo de reflexión teórica**. Resultados:** La atención a la salud del niño en Brasil pasó por un extenso proceso de evolución y calificación en el ámbito de las políticas públicas, lo que resultó en avances en la reducción de la mortalidad infantil y la desnutrición y en la ampliación de la vacunación**.** Los actuales desafíos - la mortalidad neonatal y la obesidad - se enumeran en la actual directriz programática brasileña y también en los objetivos del Desarrollo Sostenible**.** El enfermero se destacó como un profesional con participación efectiva y fundamental en la atención a la salud del niño, incluso antes de la consolidación del SUS y de la promulgación de la ley del ejercicio profesional. **Conclusión:** Para superar las lagunas entre las directrices programáticas y el alcance de esas políticas en la realidad de los servicios de salud, se hace necesaria la consolidación de la presencia y extensión de los atributos de la APS en los servicios de salud brasileños.

Descriptores: Salud del niño; Atencion primaria de salud; Políticas públicas; Enfermería.

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INTRODUCTION

In a context of reflection on the evolution of Brazilian health care public policies, regarding the moment of the 30th anniversary of the Unified Health System (UHS), it is valid to discuss child's health, considering that "their survival, protection, growth and development with good health and adequate nutrition are fundamental bases for human development (p15)"[1].

For this reason, the child's health is a priority issue in national and international debate on health and development; it was among the goals and targets set out in the declaration of the Millennium Development Goals (MDGs) and resumed in the Sustainable Development Goals (SDGs) established by the United Nations (UN) in the years 2001 and 2016, respectively[1-2].

In Brazil, child health care has been one of the priority areas in the context of public policies for several decades, passing through an extensive process of evolution[3] and enhancement, which culminated in the National Program of Integral Care to Children's Health (PNAISC - *Programa Nacional de Atenção Integral à Saúde da Criança*) currently in effect[4].

This process has been closely related to the qualification of the attention and care exercised in all dimensions, from the individual to the collective, from primary to specialized care, with the participation of various actors, with emphasis on the Nurse.

The child health care policies have resulted in many advances, with positive impacts on health indicators such as reduction of infant mortality, increased vaccination coverage, expansion of access to health services, improvement in breastfeeding rates and reduction of malnutrition.

Throughout this path, new challenges also emerged, such as the stagnation of neonatal mortality and increased incidence of prematurity, chronic conditions and violence in childhood. And, finally, some old problems that still need answers also persisted, such as the high prevalence of congenital syphilis and the morbidity and mortality of children under 5 years due to causes that are sensitive to Primary Health Care (PHC)[5].

In this context, PHC has a fundamental role in the recognition of the health needs of the population, for for organizing and coordinating care in the Health Care Network (HCN). However, its effectiveness depends on the level of structuring and how its organizing attributes work, which are distributed between essential – first-contact access, longitudinality, comprehensiveness and coordination - and derivatives - family and community guidelines and the cultural competence[6].

In the same way, the performance of the PHC team directly impacts on the consolidation of this effectiveness and, in relation to child health care, the nurse stands out, both in the historical process of implementation of policies as in facing the challenges imposed by him/her, once such professional gathers, in his/her specificities, a whole view of the individual, with skills for an assistance that adds actions for health promotion and disease prevention, focused on both individual as collective, and a recognized vocation for health education practices.

Based on the recognition of the priority nature of child health care, in the context of collective health in which the nurse acts intensely, there emerges the motivation for this theoretical reflection, whose purpose is to describe the process of historic construction of Brazilian child health care policies, the participation of nurses in this process and the advances and challenges in primary health care.

METHODS

This is a descriptive study of theoretical reflection. The survey of scientific articles was conducted at *Portal de Periódicos CAPES* (*Coordenação de Aperfeiçoamento de Pessoal de Nível Superior* – Coordination for Higher Level Personnel Improvement), without delimitation of the period of publication (since the object under study is part of a historic construction), using the following descriptors: Child health, Public policies, Primary health care and Nursing. Official publications - laws and manuals – of the Ministry of Health and international institutions available online were also used.

The bibliographic survey aimed at describing the historical construction of public policies geared to the child's health in Brazil, their main results highlighted in international discussions in this direction and the way in which the nursing positioned itself in this context. From then on, a reflection on the advances and challenges for primary care to children's health that permeated this process until the current days was built.

RESULTS AND DISCUSSION

The child health policies and actions in Brazil were designed according to the evolution of the political context, the epidemiological profile and the conceptions of health and child over time. The first government initiative in this direction occurred in the decade of 1930-1940, still during *Estado Novo*[3], when the Ministry of Health and Education created the National Department for Children (DNCr – *Departamento Nacional da Criança*). This initiative attempted to respond to the great challenge of the high infant mortality rate that, at that time, were around 162 deaths/1000 live births[5], but, on the other hand, there was also a concern to reduce absenteeism of mothers to work due to their children's illness[7].

The DNCr was established as the supreme organ of coordination of all national activities for the protection of motherhood, childhood and adolescence, which was responsible for knowing the situation of this population through surveys, promoting the formation of a social conscience about them, stimulating the creation and organization of care establishments and supervising them[3]. All this, through actions of curative and individualized character[7], including medical care, educational actions and care[8].

In this context, institutions emerged, such as centers for childcare and houses for children, intended to provide, in this first space, assistance to the health of the mother in the gravid-puerperal cycle and the child until the five years and, in the second space, educational assistance, focused on issues of morality and hygiene, and health care. In this scenario, the most active figures were neonatal doctors and teachers, who received the training carried out by the DNCr[8], so that the literature does not mention the expressive performance of nurses in this context.

In 1953, there was the dismemberment of the Ministry of Health and Ministry of Education, and in 1969, the DNCr was deposed, being replaced by the Coordination of Maternal and Child Protection (CPMI - *Coordenação de Proteção Materno-infantil*), in 1970[7]. During this period, the infant mortality rate was around 115 deaths per 1000 live births, resulting in a reduction of 1% per year since 1930, and the median age of the deaths was 30 days of life[5], which indicates some progress resulting from the actions of the DNCr, although a still quite high index, which keeps the reduction of CM as the main challenge.

In 1975, the CPMI launched the National Program for Maternal and Child Health, aiming at reducing child and maternal mortalities, from the preparation of infrastructure, concentration of financial resources, investment in the quality of information, encouragement of breastfeeding, dietary supplementation, monitoring of growth and development, deployment of a basic vaccination scheme by age, oral rehydration therapy (ORT) as a control measure for diarrheal diseases, the control of acute respiratory infections (ARIs), in addition to improving the quality and coverage of care to women during pregnancy, childbirth, puerperium and the assistance to the child[3]. In this policy, although the actions still focused on child care in acute situations, there were also some initiatives of preventive character[3,7].

In the midst of this movement of construction of the child health care policy, in which new strategies are inserted beyond the curator and medical-centered look, nursing begins to find space for expansion of its field of responsibility, with the possibility of a differentiated performance of nursing assistance in force at that time. This space is evidenced by the deployment of a nursing service, at the end of the 60's, in a training unit designed to care, teaching and research, which worked with a needy population located in a municipality in the countryside of São Paulo. This service focused on meeting the principles of primary care and the objectives of public health programs at that time, such as the attention to the child's health, especially in the first year of life. Thus, nurses performed scheduled appointments for monitoring healthy children according to a pre-established timetable and, to a lesser extent, the demands for diseases, which resulted in a positive impact in that service and demonstrated the relevance of nursing consultation in attention to the child, established as a practice, used even before its formalization in the professional practice law[9].

The actions proposed by the National Program of maternal and child health have resulted in a 3.2% reduction of the infant mortality rate per year, reaching 83 deaths per 1000 live births at the end of the 1970's[5]. In fact, this program seems to have made possible nurses' protagonism in child health care in the context of PHC, in which there is a fertile ground for their performance, because the actions established in this program are absolutely

consistent with the specificities of this professional, whose practice bases on health promotion and disease prevention, care and health education, individually and collectively.

The years subsequent to 1980 were marked by great advances in the health sector, with a significant impact on child health care policies, thanks to a context of discussion on Health Social Determinants (HSD), which resulted in the International Conference on Primary Health Care, held in Alma Ata in 1978, the resumption of the health conception, previously defined by the WHO in its constitution, as a fundamental human right, not merely the absence of disease, but a state of complete well-being. Thus, the PHC was defined as a key strategy for improving the health of the population[10]. In addition, the need for health care strategies of intersectorial character emerged to respond not only to acute situations, but also to improve the determining factors of the health of the population.

In the midst of this global debate, in Brazil, in 1980, the Program of Integral Assistance to Women's and Child's Health (PAISMC - *Programa de Assistência Integral à Saúde da Mulher e Criança*) was created, whose main actions in relation to children's health aimed at promoting breastfeeding and guidance for feeding while weaning, control of ARI, diarrhea and dehydration, basic immunization, and follow-up of growth and development[3,7], actions intensely assumed by nursing professionals in the PHC.

In 1984, the PAISMC was divide into two programs: the Program of Integral Women's Health Care (PAISM - *Programa de Atenção Integral à Saúde da Mulher*) and the Program of Integral Children's Health Care (PAISC - *Programa de Atenção Integral à saúde da Criança*)[3,7], so that the PAISC kept the lines of actions geared to the child's health, already established in the PAISMC, and contemplated the prevention and management of low birth weight, prevention of accidents and poisonings, assistance to newborns and the creation of the child's card as an instrument for monitoring growth[3]. For nursing, these two programs represented an interesting milestone for consolidating its space and way of acting in the PHC from the consultation based on health education and a comprehensive view, which considers the individual in his/her social and psychological context, which are important tools in child health care[11].

All these measures intensified the reduction of infant deaths, whose index showed a decline of 5.5% per year from 1980, reaching 47 deaths per 1000 live births in 1990[5], and began to set up the health care to the child into the molds of PHC. However, they still did not full meet the principles established in Alma Ata. Due to political and financing obstacles, in many countries, including Brazil, a model of selective PHC was adopted, focused only on some specific health problems, through a model of health centers geared to spontaneous demand, distancing themselves from the idea of completeness previously defined[12], so that the consolidation of this care model was added to these challenges.

At the end of the 1980's and beginning of 1990, in a context of the redemocratization of the country, there were great achievements in the context of public health policies - with the creation of the UHS - which marked a paradigm change, so that health began to be understood from the concept of integrality, generating policies that united protective actions, promotion and prevention[3,7].

This new paradigm resulted in a large expansion of PHC, but still based on a selective character and an individual assistance and guided by spontaneous demand. This situation began to be overcome with the creation, in 1991, of the Community Health Agents Program (PACS – *Programa de Agentes Comunitários de Saúde*) and, in 1994, the Family Health Program (FHP), currently Family Health Strategy (FHS)[6,12]. Such programs have brought, for the first time, the focus for the family and introduced the concept of coverage, proposed the replacement of the traditional primary care and reassumed the principles of integrality, hierarchization of attention, territorialisation and registration of the population, multiprofessional team and promotion of health practices and actions in an integral, continuous and equitable way[12].

The FHS potentiated effectively child health care with remarkable impact on the reduction of child mortality[5,7] and consolidated itself as the main means for monitoring children's health, especially due to the use of instruments for monitoring growth and development, encouraging breastfeeding, increased vaccination coverage and attention to prevalent childhood diseases[6].

In this context, the nurse emerged as a key figure regarding the implementation of the FHS and, specifically, child health care, while a professional capable of performing all the actions

recommended whatsoever for this public, in order to provide improvements in health promotion and prevention of diseases, standing out in the performance of puericulture[13].

The nursing puericulture consultation is an important tool for the attention to the child because it provides nurses the opportunity not only to investigate and follow the pattern of growth and development and perform, based on these, appropriate interventions, but also to identify risk situations, check immunization coverage, encourage health promotion and prevention of the most commin diseases in this phase and promote health education[14], which, undoubtedly, strengthens the principles of PHC, especially integrality.

Another strategy with remarkable impact on chid's health in the 1990's was the Strategy for Integral Attention to Management of Childhood Illness (AIDPI - *Estratégia de Atenção Integral a Doenças Prevalentes da Infância*), adopted in Brazil in 1996, which also had a considerable impact during this period, especially in the North and Northeast regions, where the rates of infant mortality were still higher in relation to the rest of the country. It was a strategy for the follow-up of the child's health to be used in the FHS for evaluating factors that affect children's health as subsidy for appropriate interventions and guidelines[7]. The strategy is quite pertinent to the nurse's performance, and may be used as the basis of the implementation of the nursing process for qualification of his/her practice in child health, since it systematizes the decision making of the professional in the curative, prevention and health promotion contexts, related to breastfeeding, promotion of healthy nutrition, growth and development, immunization, as well as the control of health aggravations such as: malnutrition, diarrheal diseases, acute respiratory infections and malaria, among others.

The deployment of PHC and the AIDIPI consolidated a change picture in the Brazilian epidemiological profile of child health, marked by an intense decline in infant mortality, which has reached a rate of 27 deaths per 1000 live births in 2000; a relative control of immunopreventable diseases, evidenced by the elimination of poliomyelitis in 1989 and the last autochthonous case of measles in 1999; a reduction in the average age of infant deaths for six days of life[5]; greater concentration of causes of infant death in those originating in the neonatal period, with an incidence of 40%[7] and an increase in the rates of prematurity, from 4% in 1980, to 10% in 2000, which became the main cause of infant mortality in the country[5].

Therefore, neonatal mortality and prematurity emerged as the main challenges. Despite the significant decline in infant mortality, its levels were higher than the desirable. In this context, several strategies were defined of national and international character in the quest to overcome these challenges.

In 2000, the Ministry of Health launched the Kangaroo Method (*Método Canguru*), which established a perinatal assistance model focused on humanized care and unique to the preterm newborn (PTNB) and its family, in a biopsychosocial approach, which seeks to minimize the adverse effects of premature birth and improve neonatal care, through an involvement of all health care network (HCN), beginning in the prenatal care and continuing even after discharge, in a joint work of the hospital unit and the PHC[7]. In September of the same year, the Millennium Development Goals (MDGs) were also launched, though which, the UN member countries committed themselves, in addition to seven other goals, to reduce infant mortality to 2/3 (which, in Brazil, was 17.7 deaths per 1000 live births) by the year 2015[7]. In 2004, the schedule of commitments to the integral health of child and infant mortality reduction was released, aiming at concentrating efforts in the organization of assistance to children, including, from the first appointment, at basic health units, until the specialized attention of the most serious cases, requiring medium- and high-complexity hospitalization, with efforts beyond the reduction of infant mortality, seeking children's quality of life[14].

This agenda presented as guiding principles: intersectoriality, universality, reception, accountability, completeness, effectiveness, fairness, teamwork, emphasis on health promotion actions, family and community participation and continuous evaluation of the assistance[15]. Care lines were proposed for covering the qualified attention to the pregnant woman and the newborn infant, neonatal screening, encouragement of breastfeeding, incentive and qualification of the monitoring of growth and development, healthy nutrition and prevention of overweight and obesity in childhood, combating malnutrition and anemia deficiencies, immunization, attention to prevalent

childhood diseases, oral health, mental health, prevention of accidents, abuse, violence and child labor and attention to disabled children[15].

At this point, the publication of the Child's Health Booklet stands out, in 2005, as a tool for integral child health surveillance, from a review and expansion of the old child's card, with the addition of several evaluation and monitoring instruments, as well as information for parents[3,16].

In 2006, through the ministerial order 399, of 22 February[17], in order to overcome the difficulties faced by the UHS at that moment, the MH proposed the Pact for Health, an instrument that involves three dimensions: Pact for Life, Pact in Defense of UHS and Management Pact in order to qualify the public management of the UHS to greater effectiveness, efficiency and quality through compromises between among UHS administrators regarding the priorities.

The Pact for Life consists of a set of health commitments expressed in goals, some of them are: the reduction of maternal, neonatal and infant mortalities and consolidation and qualification of the FHS as a model of basic halth care and as an ordering center for HCN of the UHS. In this context, the proposals were: 5% reduction in neonatal mortality, the reduction of 50% in deaths from diarrhoea and 20% in deaths from pneumonia, qualification of management and creation of the surveillance committees of death in 80% of the municipalities with population over 80,000 inhabitants[17].

In 2009, the strategy "*Brasileirinhos e Brasileirinhas Saudáveis*" (Healthy Little Brazilians) was launched, whose goal was to provide new offers of care for women and children, humanely, and strengthen those traditionally existing in bond and growth and full development of children from zero to five years. The strategy proposed the reduction of child and maternal mortality and promoted quality of life and ability to play[7]. In 2011, the Stork Network was launched as part of the HCN policy to ensure safety and quality in assistance to women throughout the reproductive cycle and integral care for the child at birth, growth and development[7].

In 2013, the "National Strategy for Promotion of Breastfeeding and Healthy Complementary Nutrition in UHS-Breastfeeding and Nutrition Strategy Brazil" (*Estratégia Nacional para Promoção do Aleitamento Materno e Alimentação Complementar Saudável no SUS - Estratégia Amamenta e Alimenta Brasil*) was implemented as a result of the integration between *Rede Amamenta Brasil* (Breastfeeding Network Brazil) and *Estratégia Nacional para a Alimentação Complementar Saudável* (ENPACS – National Strategy for Health Complementary Nutrition), aiming at qualifying primary care professionals' working process to strengthen and encourage the promotion of breastfeeding and healthy nutrition for children under two years in the Unified Health System (UHS) context[7].

After this intense movement in building policies and strategies for the health care of the child since the year 2000, there was a clear breakthrough in health conditions of Brazilian children, evidenced by the infant mortality rate, in 2015, of 15 deaths per 1000 live births, surpassing the goal number 4 of the MDGs for this country[18], added to other important achievements such as the reduction of malnutrition and deaths from diarrhoea and respiratory infections, considerable improvement in vaccination coverage and increased average time of breastfeeding and prevalence of exclusive breastfeeding[5].

However, even after nearly three decades since the UHS creation and the expansion of the services of PHC, some challenges still remain, including: certain stagnation of the neonatal mortality rates; prevalence of deaths originating in the perinatal period; prematurity still high; morbidity and hospitalization of children from causes that could be avoided with sensible and resolutive actions in PHC; the increase in chronic conditions; the high incidence of congenital syphilis; persistence of regional, socioeconomic and ethnic disparities; the increased number of children who are victims of violence[5,7]; as well as the difficulty implementing intersectoral approach to fight HSD.

These challenges reflect old barriers that have not been sufficiently achieved by policies established by then, or even a recurrent distancing between established policies and implemented actions, but also highlight new problems resulting from living and health conditions of the current population. Nevertheless, in general, many of these challenges are directly or indirectly related to quality of care to child health in the PHC, as exemplified below.

Regarding hospitalizations from preventable causes, a systematic review of the literature identified that the main reasons for

hospitalization of children under five, in Brazil, from primary care-sensitive causes (PCSCH), were pneumonia, gastroenteritis and asthma. Among children under one year, urinary tract infections also represented important cause of hospitalization, which could also be reduced by early diagnosis, timely treatment and, in cases of recurrence, appropriate prophylaxis still at outpatient level[19].

Given this, the importance of using existing instruments such as AIDPI and the nursing process as a means of qualifying the attention to child health stands out once again, aiming at a more efficient and decisive assistance in PHC. Allied to that, there is the need for appropriately including PHC attributes for qualification of this level of attention, avoiding aggravations and hospitalizations fron causes that might be appropriately resolved still in PHC.

When assessing the presence and extent of PHC attributes in relation to children under five years, hospitalized from pneumonia, a case-control study identified that the attributes representing availability of services, supply of health actions and involvement of professionals with the family in its life context, proved to be more widely present in those who were not hospitalized, which proposes an association of these with the prevention of hospitalization from pneumonia[20].

One of the chronic diseases in childhood is childhood obesity, which shows growing trend in Brazil and presents itself as a risk factor for other chronic diseases such as hypertension, diabetes, renal, cardiovascular and brain diseases[21].

There is a clear change in the epidemiological profile of the Brazilian childhood. First, efforts were concentrated in combating malnutrition, currently nearly surpassed in this country, the challenge is to overcome childhood obesity. Interestingly, both challenges - fighting malnutrition and obesity - are listed among the goals of the SDGs[2] and even have similar means for their resilience, such as: the monitoring of growth curves, encouraging breastfeeding and appropriate guidance for introducing new foods and healthy eating[4].

Congenital syphilis is also a relevant problem in this context, which can be overcome with efficient actions in the PHC, once cases of the disease are associated with socioeconomic conditions and quality of prenatal care[22]. Here, it is evident the importance of integrality and longitude attributes, as this issue raises efforts not only in actions directed to children's health. In the case of congenital syphilis, the bottleneck is in the assistance to women's health, so that this challenge can be overcome through a qualification of reproductive health care, including from family planning to prenatal care, as established by SDGs[2].

Regarding the current challenges for childen's health, in August 2015, through ministerial order 1130[4], MH launched the *Política Nacional de Atenção Integral à Saúde da Criança* (PNAISC – National Policy for Children's Health Full Attention), which expanded the focus of children's health care up to nine years old, but kept special attention to early childhood (0-3 years) and greater vulnerability, aiming at reducing infant morbidity and mortality, as well as promotion of a conducive atmosphere for life with conditions of existence and full development for this population. Thus, the guiding principles of this policy are: right to life and health; child's absolute priority; universal access to health; care integrality; health equity; conducive atmosphere for life; care humanization and participatory management with social control[4].

The PNAISC is structured in seven axes, each one contemplating strategic actions specific to its implementation: humanized and qualified attention to pregnancy, elivery, birth and newborn; breastfeeding and healthy complementary nutrition; promotion and monitoring of growth and development; comprehensive care to children with diseases prevalent in childhood and chronic diseases; comprehensive care of the child in situations of violence; prevention of accidents and promotion of a peaceful culture; health care of disabled children or in specific and vulnerability situations and monitoring and prevention of infant, maternal and fetal death[4].

The challenges faced in Brazil in relation to children's health are similar to those in other nations and, similarly, can be answered through global initiatives. In 2016, the UN launched the 2030 Sustainable Development Agenda, which seeks to resume the Millennium Goals still unreached and establish new goals relevant to the new challenges of humanity for sustainability. This agenda also includes children's health among the priority items, with an integral vision, covering the issues of education, safety, health care of children and women, as already mentioned in this text[2].

Therefore, the following issues emerge: What is the nurse's role in confronting the challenges and implementing policies for children's health care, from an expanded health concept? Which aspects of the PHC and the professional experience need to be qualified in order to overcome these challenges and successfully implementat PNAISC and SDGs?

Through all these challenges, the nurse has a key role, whether at the individual level, through nursing consultation with appropriate follow-up of growth/development and timely and efficient guidelines, either at the collective level, with health education activities, also representing an effort at the intersectoral and multiprofessionals level.

Generally speaking, nurses recognize the value of childcare consultation to child health assurance and perceive it as a systematic and periodic follow-up of the child which includes his/her growth and development[23], also demonstrating job satisfaction in performing their activity[13].

In this sense, inadequate training for monitoring growth and, in particular, development of children under one year old in the FHS was a decisive factor for the flaws in the quality of the nursing consultation, pointing to the need for properly training such professionals to assist this audience[13,24].

Other research on the use of the Child Health Booklet showed that this instrument extends the field of practices in the nurse's point of view, enabling a dialogue with the mother and her family about the health of the child, but, at the same time, presented some problems such as incomplete filling of the instrument by professionals and the limitation of knowledge of some of these individuals about it[16].

On the other hand, some professionals pointed out deficiencies in the structure of services, especially in relation to the availability of instruments/equipment for monitoring the growth and development of the child as contributors to performing inappropriate actions in the process[13].

Thus, nursing has a key contribution to consolidate the UHS assistencial model, which means a transposition from a working process centered on procedures and professionals into a user-centered process, based on the ethical imperative of the expanded clinic, whether for organizing services as for the professional performance[24].

Regarding the quality of health care of the child in the PHC, the study pointed out that the Brazilian basic attention services are heterogeneous with regard to the presence and extent of PHC attributes for the child[6]. Thus, a study in 11 municipalities of Minas Gerais showed that, in the view of caregivers of children from 0 to 2 years old, the health care of the child is not imbued with many of the PHC attributes, evidenced by the presence of organizational barriers to access, absence of counterreference, predominance of individual practices, lack of health promotion actions, verticalized organization of actions, inefficient communication between professionals and users and little room for community participation[25].

CONCLUSION

The child health care in Brazil, as one of the priorities in the context of public policies, went through an extensive process of construction along the history, from a model focused on disease and healing actions to another, based on an expanded health vision, focused not only on curative actions, but also on preventive and health promotion and protection.

Resulting from the 30 years of UHS and its advances in the implementation of constitutional principles and guidelines, in particular, the universality and decentralisation, there have been significant progresses such as reduced infant mortality, expansion of access to services, high vaccination coverage and reduced malnutrition. Nevertheless, other challenges have emerged as the stagnation of neonatal mortality and increased incidence of prematurity and chronic conditions.

Therefore, there have been and there are still gaps between the programmatic guidelines and the capillarity of these policies on the reality of health services. Now, the target of recent PNAISC is to provide, to the developing child, a better quality of life, especially to the most vulnerable groups, such as indigenous, *quilombolas*, bordering and disabled children. This policy also advocates the integral care to children with diseases prevalent in childhood and with chronic diseases.

In addition, PHC stands out with an important role in coping with these challenges; however, its effectiveness depends on its degree of organization and the presence and extension of its attributes and, in this regard, there is still much to do. Then, it becomes necessary to invest

in adequate training of professionals, since they are responsible for the enforcement of public policies.

Nursing has emerged as an important character in child health care, even before the consolidation of the UHS, due to its potential to offer assistance with a broader vision of the individual, with practice of health promotion, such as the health education, but there is still need to advance in continuing education strategies, in academic formation at the graduation level - which is still marked by the biomedical model - and in postgraduate school, expanding the offer of specialization in the residency modality.

As above, there is still much to move, either in qualifying the PHC for the assistance to the child's health or in the training of nursing professionals for implementing PNAISC and targets for sustainable development in relation to the child's health, especially regarding their ability to contribute to the implementation of a model centered on procedures and professionals for a user-centric model; the use of instruments such as the AIDPI; the nursing process and the child's health booklet, aiming at identifying of real and potential problems of the individual and his/her family with proper routing to the nursing interventions.

In the face of such reflections, other studies need to be developed with a view to understand how presence and extension of the PHC attributes are, including in the professional's view, in order to subsidize the improvement of the quality of these services, to be efficient in coping with the current challenges in the context of child health. Studies seeking to understand the knowledge of nursing professionals about the PNAISC and SDGs for the child's health are also necessary, as well as of instruments available for guiding practice in the PHC.

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