

THE NURSING WORK PROCESS IN CARE FOR HEALTHY CHILDREN AT A SOCIAL SECURITY INSTITUTION IN MEXICO¹

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We aimed to analyze the nursing work process directed at care in the Nutrition, Growth and Development Surveillance and Control Program (VNCD) for children under five years at a social security institution in Mexico. The study adopted a qualitative approach and was based on the work category, on conceptions of the work process in health and on institutional analysis. We carried out direct systematic observations and interviews with a group of nurses and their assistants and with mothers who attended nursing appointments with their children. The care process was identified as procedure-centered and based on care protocols, with rapid appointments and little room for interaction between nurses and mothers. However, on some occasions, nurses were capable of producing live work as a result of their self-government, which allowed them to establish a mother/child-centered care nucleus.

DESCRIPTORS: child care; maternal-child nursing; biomedical technology

EL PROCESO DEL TRABAJO DE LA ENFERMERA EN EL CUIDADO AL NIÑO SANO EN UNA INSTITUCIÓN DE LA SEGURIDAD SOCIAL DE MÉXICO

El objetivo fue analizar el proceso de trabajo de la enfermera en el Programa de Vigilancia y Control de la Nutrición, Crecimiento y Desarrollo (VNCD) del menor de cinco años, en la Seguridad Social de México. El estudio, de aproximación cualitativa, se fundamentó en la categoría trabajo, en los conceptos de proceso de trabajo en salud y en enfermería, en la micropolítica del trabajo vivo en salud, así como en el análisis institucional. Se realizaron observaciones sistemáticas directas y entrevistas a un grupo de enfermeras, sus asistentes y a las madres que acudieron con sus hijos a la consulta de enfermería. El proceso de cuidado identificado fue procedimiento-centrado, basado en protocolos de atención con consultas rápidas y con poco espacio de interacción entre la enfermera y la madre. Sin embargo, la enfermera fue capaz de producir, en ocasiones, trabajo vivo a partir de su autogobierno, permitiéndole establecer un núcleo de cuidado madre/hijo-centrado.

DESCRIPTORES: cuidado del niño; enfermería materno-infantil; tecnología biomédica

O PROCESSO DE TRABALHO DA ENFERMEIRA NO CUIDADO À CRIANÇA SADA EM UMA INSTITUIÇÃO DA SEGURIDADE SOCIAL DO MÉXICO

O objetivo foi analisar o processo de trabalho da enfermeira orientado ao cuidado no Programa da Vigilância e Controle da Nutrição, Crescimento e Desenvolvimento (VNCD) do menor de cinco anos na Seguridade Social do México. O estudo, de abordagem qualitativa, se fundamentou na categoria trabalho, nas concepções do processo de trabalho em saúde e em enfermagem, na micropolítica do trabalho vivo em saúde assim como na análise institucional. Realizaram-se observações sistemáticas diretas e entrevistas com um grupo de enfermeiras, suas assistentes e as mães que compareceram com seus filhos à consulta de enfermagem. O processo de cuidado identificado foi o procedimento-centrado baseado em protocolos de atenção, com consultas rápidas e pouco espaço de interação entre enfermeira e mãe. No entanto, a enfermeira foi capaz de produzir, em ocasiões, trabalho vivo a partir do seu auto-governo, o que lhe permitiu estabelecer um núcleo de cuidado mãe/filho-centrado.

DESCRIPTORES: cuidado da criança; enfermagem materno-infantil; tecnologia biomédica

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INTRODUCTION

Children constitute a priority group in global health care efforts. During the World Summit for Children 1990, a Declaration and an Action Plan were adopted, with 27 goals for the survival, development and protection of children and adolescents. Among these, newborn care, breastfeeding promotion, follow-up of child growth and development, immunizations, as well as prevention and control of diarrheic and acute respiratory diseases stand out.

The follow-up of child growth and development, which health professionals and users also identify as Healthy Child Care, is a central component in community health services. This care contains three main elements: immunization, growth and development assessment and health education. It can be practiced by physicians or nurses⁽¹⁾. In Mexico, these actions are covered by the Official Mexican Standard for Child and Adolescent Nutrition, Growth and Development Control, issued in 1994. Child care implies implementing health promotion, diagnosis, treatment and maintenance activities which, in the case of the Mexican Social Security Institution, are part of the Nutrition, Growth and Development Surveillance and Control Program for children under five years (VNCD). The VNCD is a strategy for integral care delivery, aimed at raising health levels in the population under five years old, decreasing malnutrition rates in the child and preschool population and reducing morbidity and mortality in this group⁽²⁾.

Social Security is the main component of the Mexican Health System and attends about 50% of the population. The VNCD program is developed at Family Medicine Units (FMU) by teams that consist of: family physician, social worker, psychologist, dentist, nutritionist, medical assistant of the maternal-infant nurse (AEMI) and maternal-infant nurse (EMI)⁽²⁾. Newborns are assessed by the family physician during the first three months, who refers them afterwards to the EMI to continue VNCD care up to the age of five. The main EMI activities include: deliver VNCD care to children under five years, detect risk factors, comply with family physician's indications and educate mothers or responsible family members to achieve favorable habits and behavior⁽²⁾.

Research has assessed the quality of EMI care to children in this program through quantitative indicators, such as the number of visits during the first year of life and immunizations. However, these

studies have not performed a qualitative assessment of how this care is delivered, its goals and how accompanying mothers perceive it⁽³⁾.

This research aims to analyze the work process of maternal-infant nurses (EMI) in a Nutrition, Growth and Development Surveillance Program for children under five years (VNCD) at a Social Security Institution in Mexico, focusing on the nursing care production process.

THEORETICAL FOUNDATIONS

This study was based on theoretical considerations about work in the Marxist conception⁽⁴⁾, in combination with considerations that study its particularities in health⁽⁵⁾ and in nursing⁽⁶⁾. It is also based on micro-political conceptions of work in health⁽⁷⁾ and in instituting and instituted processes⁽⁸⁾.

Work constitutes an essential category to study social practices, including those in health and nursing. The components of the work process are "the activity that is adequate for a goal, that is, work itself; the matter the work is applied to, the work object; the work means, the work instruments"⁽⁴⁾.

In health, in order to apprehend the work object, i.e. man and his needs, agents need to use work instruments, in the intellectual (knowledge for example) and material dimensions (tools, machines, devices)⁽⁵⁾. They also need to establish interactive relations with users, producing subjectivities⁽⁹⁾.

The theoretical conception sustaining the instituting process emerges from the Institutional or Instituting Movement, joining different currents developed by French and Latin-American authors. Three main branches are found in Latin-American literature: Gérard Mendel's sociopsychanalysis, institutional analysis by Georges Lapassade and René Lourau, and schizoanalysis by Félix Guatari and Gilles Deleuze. This study takes some concepts these currents have in common, such as instituting and instituted processes and molar and molecular⁽⁸⁾.

All production processes have a product, generate a result. That is the instituted. "The instituted is the effect of an instituting activity (...) the instituting appears as a process, while the instituted appears as a result. The instituting transmits a dynamic characteristic and the instituted transmits a static, frozen characteristic"⁽⁸⁾. The instituted is important, but it has to follow the dynamics of transformations

in social life. In this sense, the instituting is not always good, nor is the instituted bad. "The instituting appears as a revolutionary, creative and transforming activity *par excellence*. In fact, it is not exactly like that, because the instituting would lack all meaning if it were not shaped, if it did not materialize in the instituted. On the other hand, the instituted would not be useful, would not be functional if it were not permanently open to instituting powers" ⁽⁸⁾. The concepts of molar and molecular refer to the macro and micro-spheres that are immanent. Thus, social life is a network in which these areas are present. The small, local (molecular) connections are the place of the instituting ⁽⁸⁾. Hence, it is in the micro-politics of work that production processes of subjectivity occur.

The terminology used in this text (health production, health care production, productive act) is based on institutionalism, which defines production as "what processes everything that exists naturally, technically, subjectively and socially" ⁽⁸⁾. In health production, it means producing goods/products, subjectivities and relations to attend to individual and collective health needs.

Nursing as a social practice (as work) can be studied in terms of performance, identifying its moments, care subject/object, work agents, instruments and purpose, for which the concept of technological work organization was considered ⁽⁶⁾. Technology in this concept does not only refer to the meaning the set of material instruments has in common, but is also considered as a set of knowledge and means expressed in service production processes, the network of social relations in which its agents articulate their practice in a social totality ⁽⁵⁾. In addition to this concept, there is the "typology of technologies", including light (bonding, autonomization, welcoming), light-hard (well-structured knowledge of health areas and professionals) and hard technologies (technological equipment like machines, standards and organizational structures) ⁽⁷⁾. The meeting between health professionals and users occurs through light technologies. This classification of technologies in health allows us to understand the micro-politics of health work, presenting the discussion about workers' self-government and live work in action ⁽⁷⁾.

The health work process contains both live and dead work, and one can prevail over the other. Dead work refers to all products-means present in work (either as tools or raw material) and which result from earlier human work. Live work means work in

action, produced by "occurring" in the act of its realization, allowing for instituting processes. The worker can possess a certain degree of self-government, which will be characterized by the action of his/her live work on what (s)he is offered as dead work and the goal (s)he is aiming for. This is immediately consumed by users in the production of the action. Thus, in the case of production/consumption in health, a space for interaction and intervention is constructed between the user and the worker who produces the action, in which both the user and the worker institutes needs and ways of capturing them, of acting ⁽⁷⁾. In health care acts, the live work dimension is expected to prevail, as it operates with relationship technologies, subjectivity encounters, spaces for welcoming and listening, beyond structured technological knowledge and equipment. The dead work recorded in materials, standards, routines and care protocols is undoubtedly important for the production of health acts. However, these instruments are not sufficient to produce care centered in users' needs.

We consider care as the soul of health services, as the essence of nursing, as its central, dominant and unifying characteristic. This is about a therapeutic intervention that must center in users' needs. In the case of EMI visits, nurses are responsible for producing a care nucleus, that is, a space for worker-user interaction that allows for listening, as well as bonding and confidence, permitting mothers to express their doubts related to care for her health and that of her children ⁽⁷⁾.

METHODOLOGY

Qualitative methodology was considered appropriate for this study, as it allows for a critical and reflexive analysis of the EMI work process. Study participants, identified as health personnel, were: four nurses (EMI) who carry out VNCD visits and two medical assistants of EMI (AEMI), responsible for receiving users, in this case mothers/children. We also included 25 mothers who attended the visits with their children and identified themselves as such, since we consider them as the subject/object of nursing care.

Data collection techniques were: direct systematic observation of 87 EMI visits and observation of the reception area where AEMI are active, besides semi-structured interviews with this

health staff (6 interviews) and interviews with the mothers (25 interviews). The techniques were applied until data saturation was reached and until the meaning of the EMI work process was understood. Before the observations and interviews, participants received explanations about the research objectives and signed the free and informed consent term.

Aspects were registered in terms of how care is produced during the visit, including duration, interactions, dialogues between health staff and mother/child user, accomplished procedures and how they were accomplished, instruments used, as well as general aspects to characterize children attending the visits (age, gender, first or subsequent visit). Data were registered on an instrument especially designed for this purpose.

Interviews were audio-taped. In the case of health professionals, interviews looked at care production aspects, allowing subjects to freely express their opinions.

Mothers were approached when they left the EMI visit. Twenty interviews were held in the waiting room, distanced from the EMI work area, and five at participants' homes, totaling 25 interviews. The technique looked at care production aspects, allowing mothers to freely express how they perceived care, if they had the opportunity to manifest their concerns and needs during the visit, and how the AEMI and the EMI treated and interacted with herself and her child. Data were collected between February and July 2004.

Data were analyzed by means of thematic analysis. The idea of theme is connected with an affirmation related to a particular subject, trying to discover the units of meaning that integrate a communication, whose presence or frequency means something for the proposed objective⁽¹⁰⁾. From a qualitative perspective, the presence of certain themes indicates the reference values and behavioral models that are present.

Three themes were identified: institutional configuration, EMI care production and healthy child control. We decided to discuss and analyze nursing care production because the nursing work process in healthy child control is the central object of this study. In terms of *nursing care production*, we analyzed aspects related to the dynamics of the work process, the object/subject of work, responsible agents, processes occurring in the interior of the worker/interaction space, live work/dead work, technologies and self-government of health personnel, production

of a procedure-centered or user-centered (mother/child-centered) care nucleus.

In the last phase, we considered the identified empirical thematic units and correlated them with theoretical conceptions, which allowed us to reconstruct the moments of the EMI work process and reach conclusions.

This study was carried out in line with ethical guidelines proposed in the General Health Law for Health Research in Mexico and was authorized by the State's Health Research Coordination.

RESULTS AND DISCUSSION

In the cases we studied, mothers assume the role of caregiver for their children, which is why health professionals consider them as the subject/object of EMI care: *Children are totally dependent on their mothers (Int. EMI 3)*. This situation makes health staff think, in general, that it is always the mother who comes to the visit. Consequently, verifying the family relation between the child and the person accompanying is not a part of routine. Data like the companion's age, number of children, education level, among others, are not verified either during visits.

In our study, mothers' mean age was 29 years. They had finished high school (11 years), were housewives (76%) and married (76%). The children's mean age was 12 months. Average waiting time to receive care was 19 minutes, rising up to 90 minutes in two cases. Eighty-four percent of the visits were subsequent.

Both health professionals and mothers mentioned an unfavorable economic situation as one aspect that made them visit the service. This is according to literature, which indicates socioeconomic situation as a determinant factor in health service selection⁽¹¹⁾. Mothers related the economic question with milk donation, which appeared as an aspect that oriented/disoriented care: *Most people are interested in the milk because of the economic situation, a box of milk costs 60 to 80 pesos and only lasts 3 days (Int. AEMI), I don't have milk anymore, I was buying it, but it costs 55 pesos and sometimes you don't have that money (Int. mother 8)*.

Health professionals acknowledge that mothers' education level and the existence of groups with special care needs, such as adolescent and working mothers, have been increasing. However, this does not change the way care is delivered. One of the

interviewed mothers indicated that power prevails over academic level, which raises a strong impediment to dialogue: *Your academic level gives you security but, over there, all of them believe they have power, they diminish you and believe that everybody who goes there is illiterate (Int. mother 25).*

The mothers mentioned relationship technologies as an essential element in care delivery and requested that users be recognized as human beings with needs: *They should see us as human beings, if you go there it's because you need to, and nobody should have to leave there and need to see a shrink, because of what they do to you (Int. mother 25).*

Another interesting aspect was that the mothers indistinctly identified the EMI as physicians or nurses, indicating that the EMI did not like to be identified as physicians. Some considered the fact that they are nurses as adequate, highlighting the need for knowledge updating. However, the mothers mentioned that the EMI did not like to be identified as doctors, but the EMI did not perceive that she is reproducing the medical model, centered in anatomic-physiological parameters. This situation has already been registered in other studies of outpatient as well as hospital care⁽¹²⁾.

The EMI waste many opportunities to identify and answer the companions' concerns and questions. The care delivered in the VNCD program under analysis constitutes a procedure-centered health practice. The way health care is produced does not achieve integrality, which is considered to be the acknowledgement of the complete range of user health-related needs. This makes it more difficult to establish long-term relations that produce EMI-mother bonding, which is one of the principles of primary care⁽¹³⁾.

EMI staff carried out 12 healthy child control visits per day, which are programmed to take 10 minutes each. We observed 87 visits and identified a mean duration of 11 minutes, ranking from four to 32 minutes. The mothers qualified the visits as fast and added that, sometimes, it is not worth it to wait a long time to be attended in a fast and routine way. Moreover, EMI staff identified the issue of programmed visit time as a limiting factor to establish the worker/user interaction space. Neither the programmed time of 10 minutes, nor the average observed time of 11.34 minutes is sufficient to allow for the establishment of a mother/child-centered care nucleus. These data are similar to the duration of 11.85 minutes for Family Health Program visits by female physicians in Brazil,

in comparison with 9 minutes for male physicians in the same program. Furthermore, it should be pointed out that longer visit times are associated with better care quality: better questioning, better explanation of the problem and verification by the physician about the patient's understanding⁽¹⁴⁾.

In order to identify whether care production was procedure or user-centered, we analyzed the worker/user interaction space, and identified that nursing visits followed the same systemization as protocols and were only differentiated by the children's age, which was under one or between one and four years old. What characterized EMI visits to children of less than one year old was that they verified weight; measured height and head, chest and abdominal circumference; compared weight and height measures with recommended levels on the institution's tables; revised the vaccination card; gave a prescription for milk donation; registered data in the child's file, referred the child for preventive dental care and preventive medicine for vaccination, and asked the mother to make the next appointment with the AEMI. Practically the same procedures were carried out in children between one and four years old, except for circumference measurements, and children were screened for flat feet. Therefore, the EMI's live work is captured by their dead work because of the institutional configuration expressed in the service protocols and routines. The protocols produced in health care to guarantee minimal care aspects for specific groups or diseases can provoke alienated work when they are used mechanically, and can make it difficult to listen or identify other user needs, beyond those covered in the protocols⁽¹⁵⁾.

The monosyllabic communication pattern and rapid way of performing the visit makes mothers confused about the indications that are given. There is great concern about obtaining information from mothers about the child's nutrition, as well as data related to growth and development, with a view to registering them in the child's file, without the goal of providing a space, through these questions, for mothers to express their doubts, feelings, difficulties and needs to take care of their children. Thus, the established dialogue was much more of a monologue from the EMI towards the mother. This result is in line with other studies that indicate that 65% of patients are interrupted by physicians 15 seconds after they have started to explain their problem and that patients' fears and anxieties are not explored in 91.4% of the visits⁽¹³⁻¹⁴⁾.

The EMI provide reduced and incomplete information to the AEMI. Therefore, we cannot consider this as health education, understanding the latter as education for transformation, seeking to break with power-centered education methods and promoting individual and group participation in the identification and critical analysis of their problems.

Mothers expressed the need for the EMI to reaffirm their autonomy in care for their children's health. None of them considered the health staff (EMI and AEMI) as advisers or educators, which goes against other studies carried out in the USA, which concluded that, in general, nurses are more active in health advice and education in comparison with physicians⁽¹⁾. However, we could also identify that, sometimes, the EMI were capable of producing live work, creative work, mainly based on their self-government, which allowed them to get out of the institutional configuration and manage to pay attention to users' needs. This was facilitated by the bonding established when the mother is attended by the EMI during pregnancy and subsequent child care in the VNCD program.

AEMI work is reduced to the control of users who visit the EMI and directed at making first and subsequent appointments. Her activity is routine and the information she provides is limiting to showing users where some services are located. We also found that, at different times and in different situations, service access is intercepted by these professionals.

EMI who are currently working at the service are specialist nurses. Education is not offered to attend

to their training needs. Therefore, much knowledge is acquired in daily experience. No academic preparation in health is required to become an AEMI. These professionals are trained at the units.

FINAL CONSIDERATIONS

The mothers considered that the EMI possess knowledge. EMI work was identified as centered on hard technologies, that is, on care protocols and the institutional configuration. The time destined for the VNCD program is another factor favoring the production of procedure-centered visits, leaving little room for instituting processes. However, it are light and interaction technologies that allow for the establishment of a mother/child-center care nucleus, since mothers perceive that confidence is established and developed through interaction with the EMI, starting with prenatal care and covering subsequent child care.

In the health team that carries out the VNCD program, the EMI could contribute to greater approximation between health staff and users through listening and bonding, as well as to the achievement of integral child health care. This can happen through live work by EMI, based on their self-government, which allows them act beyond the institutional configuration. We recommend the flexibilization of standards and routines and educational reflection with health professionals, in order to restore the relation between workers and the goal of their work, which is the integrality of care.

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