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Nurses' leadership in child health consultations: a socio-historical study

Protagonismo da enfermeira na consulta em puericultura: um estudo sócio-histórico

Protagonismo de la enfermera en la consulta de puericultura: un estudio sociohistórico

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ABSTRACT

Objective: To analyze the work of nurses in child health consultations in Primary Health Care.

Method: A socio-historical study with a qualitative approach, grounded in the Thematic Oral History technique. The participants were 15 nurses from Primary Health Care in a municipality in southern Brazil. Data were collected between September and November 2023 through semi-structured interviews. The interviews were submitted to a transcreation process.

Subsequently, thematic analysis was performed with the support of ATLAS.ti 9® software, and the findings were interpreted based on Eliot Freidson's Sociology of Professions.
Results: Three categories emerged: Nursing consultations in child health: childhood health problems; Difficulties faced in nursing consultations in child health; Nurses' leadership: building bonds and autonomy in child health consultations.
Final considerations: Child health consultations strengthen nurses' autonomy and leadership in Primary Health Care by articulating technical-scientific knowledge, clinical judgment, family bonding, prevention of health problems, and health surveillance. However, this practice is marked by social vulnerabilities, structural limitations, difficulties in longitudinal care, and physician-centered resistance. The findings indicate the need for continuing education strategies, clinical training, and intersectoral actions to qualify and strengthen nursing practice in this area.
Descriptors: Child Care; Nursing Assessment; History of Nursing; Primary Health Care; Professional Autonomy.

RESUMO

Objetivo: Analisar a atuação da enfermeira na consulta de puericultura na Atenção Primária à Saúde.
Método: Estudo sócio-histórico, com enfoque qualitativo e fundamentado na técnica da História Oral Temática. Participaram 15 enfermeiras da Atenção Primária à Saúde de um município do Sul do Brasil. A coleta foi realizada entre setembro e novembro de 2023 mediante entrevistas semiestruturadas. As entrevistas foram submetidas à transcriação. Posteriormente, foi feita a análise temática com auxílio do *software* ATLAS.ti 9® e a interpretação dos achados foi fundamentada na Sociologia das Profissões, de Eliot Freidson.
Resultados: Emergiram três categorias: Consulta de enfermagem em puericultura: os agravos infantis; Dificuldades enfrentadas na consulta de enfermagem em puericultura; Protagonismo da enfermeira: construção de vínculo e autonomia nas consultas em puericultura.
Considerações finais: A consulta de puericultura fortalece a autonomia e o protagonismo da enfermeira na Atenção Primária à Saúde, ao articular conhecimento técnico-científico, julgamento clínico, vínculo familiar, prevenção de agravos e vigilância. Contudo, essa prática é marcada por vulnerabilidades sociais, limitações estruturais, dificuldades na longitudinalidade do cuidado e resistências médico-centradas. Os achados indicam necessidade de estratégias de educação permanente, formação clínica e ações intersetoriais para qualificar e fortalecer a enfermagem nessa área.
Descritores: Cuidado da Criança; Avaliação em Enfermagem; História da Enfermagem; Atenção Primária à Saúde; Autonomia Profissional.

RESUMEN

Objetivo: Analizar la actuación de la enfermera en la consulta de puericultura en la Atención Primaria de Salud.
Método: Estudio sociohistórico, con enfoque cualitativo y fundamentado en la técnica de la Historia Oral Temática. Participaron 15 enfermeras de la Atención Primaria de Salud de un municipio del Sur de Brasil. La recolección de datos se realizó entre septiembre y noviembre de 2023 mediante entrevistas semiestructuradas. Las entrevistas fueron sometidas a la transcreación. Posteriormente, se realizó análisis temático con el apoyo del software ATLAS.ti 9®, y la interpretación de los hallazgos se fundamentó en la Sociología de las Profesiones, de Eliot Freidson.
Resultados: Emergieron tres categorías: Consulta de enfermería en puericultura: los

problemas de salud infantil; Dificultades enfrentadas en la consulta de enfermería en puericultura; Protagonismo de la enfermera: construcción de vínculo y autonomía en las consultas de puericultura.
Consideraciones finales: La consulta de puericultura fortalece la autonomía y el protagonismo de la enfermera en la Atención Primaria de Salud, al articular conocimiento técnico-científico, juicio clínico, vínculo familiar, prevención de problemas de salud y vigilancia. Sin embargo, esta práctica está marcada por vulnerabilidades sociales, limitaciones estructurales, dificultades en la longitudinalidad del cuidado y resistencias médico-centradas. Los hallazgos indican la necesidad de estrategias de educación permanente, formación clínica y acciones intersectoriales para cualificar y fortalecer la enfermería en esta área.
Descriptores: Cuidado del Niño; Evaluación en Enfermería; Historia de la Enfermería; Atención Primaria de Salud; Autonomía Profesional.

INTRODUCTION

Child health care (puericulture) refers to a set of health actions aimed at providing comprehensive care to children. Historically established in the health care setting, the concept remains a subject of debate regarding its conceptual accuracy. In Brazil, following the 1988 creation and subsequent implementation of the Unified Health System (*Sistema Único de Saúde* - SUS), whose principles are comprehensiveness, universality, and equity, child health care became increasingly strengthened within the scope of Primary Health Care (PHC)[1].

In this context, the advancement of public policies aimed at protecting children, such as the enactment of the Child and Adolescent Statute (*Estatuto da Criança e do Adolescente* - ECA) in 1990, reinforced the guarantee of rights and the absolute priority of children in health care initiatives[2]. In the health care field, nursing consultations in child health became established as a practice focused on health promotion, disease prevention, and comprehensive child follow-up, contributing to the advancement of professional nursing practice and to the improvement of child health care[3].

According to the Ministry of Health, systematic follow-up through child health consultations is essential for optimal child growth and development. This care should be provided alternately by nurses, family physicians, and, when necessary, pediatricians. To ensure effective child follow-up, a minimum schedule of seven consultations during the first year of life, two during the second year, and annual consultations from the third year onward is recommended. This practice is guided by technical guidelines from the Ministry of Health, in accordance with the Child Health Handbook and the Primary Health Care Guidelines[4,5]. These recommendations provide national guidance for the organization of child health care in PHC and are implemented by Family Health Strategy (FHS) teams according to regulations,

care pathways, and the organization of the health care network in each territory. In this context, protocols, continuing education activities, health monitoring, and coordination among the different points of the Health Care Network (HCN) contribute to improving the quality of care provided to children. Thus, child health consultations facilitate care pathways, complementary services, and shared care with specialized health services, contributing to continuity and comprehensiveness of pediatric care[5,6].

The literature highlights that nursing consultations in child health are characterized by an emphasis on comprehensive care, the promotion of family bonding, and active child health surveillance. Their dynamics distinguish them from medical consultations in child health care. On the one hand, nursing practice is guided by the Systematization of Nursing Care (SNC) and the Nursing Process (NP) as methodological tools for engaging families and promoting autonomy in care[7,8], on the other hand, medical consultations in child health primarily focus on clinical management, diagnostic accuracy, and prescribing appropriate treatment for pediatric health conditions. Thus, although methodologically distinct in their approaches, both converge toward comprehensive care, ensuring that children's biological and social needs are fully addressed[9].

Furthermore, nursing practice in child health consultations involves monitoring children's physical, motor, and cognitive growth and development. This process includes periodic assessments, such as analysis of primitive reflexes, evaluation of developmental milestones, measurement of anthropometric parameters (head and chest circumference, height, and weight), guidance on nutrition (breastfeeding and complementary feeding), monitoring of the vaccination schedule, and disease prevention actions targeting common diseases in early childhood[10].

In Florianópolis, Santa Catarina (SC), the organization of child health care was strengthened by the Capital Child Program (*Programa Capital Criança* - PCC), implemented in 1997, which constitutes the starting point of this study. Created and designed by an interdisciplinary team comprising nurses, pediatricians, and educators, the PCC remains in place as a relevant strategy for promoting safe motherhood and healthy child development[11]. Furthermore, the temporal scope of this study extends to 2018, a year marked by the implementation of nursing protocols in the municipality, which provided greater technical and legal support for nursing practices in PHC[5].

Despite the extensive framework of laws, public policies, and protocols aimed at child health, the practice of child health consultations in PHC still faces obstacles regarding

nursing autonomy. Studies show that, although nurses have legal and technical support, these professionals frequently lack recognition, particularly in settings characterized by physician-centered care and low professional appreciation. These difficulties are associated with a lack of understanding of their strategic role, work overload, and the limited visibility of nursing among society and other health professionals. These findings reflect a historical social construction that privileges the biomedical model and renders health promotion–centered care invisible, hindering the recognition of child health consultations beyond the nursing field[12,13].

In this context, this research is relevant for highlighting nurses' leadership in promoting child health, based on the Sociology of Professions developed by sociologist Eliot Freidson, to analyze the interrelationship among specialties in the health field, expertise, credentialism, and autonomy, which characterize professions[14]. Given the consolidation of these practices and norms, the following research question was posed: How is nurses' role in child health consultations characterized within the context of Primary Health Care? Therefore, this study aims to analyze nurses' role in child health consultations in Primary Health Care.

METHOD

This is a socio-historical study with a qualitative approach, grounded in the Thematic Oral History technique and the principles of historical research in nursing[15]. The study's historical-analytical time frame encompasses the work of nurses in Basic Health Units (BHU) in the municipality of Florianópolis, Santa Catarina, Brazil, between 1997—the year marked by the implementation of the PCC—and 2018, the year in which the Nursing Protocol for Child Care Needs was established. The report of this study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines[16]. Following thematic analysis, the findings were interpreted considering Eliot Freidson's Sociology of Professions, particularly based on the concepts of professional jurisdiction, autonomy, and expertise[14].

The research setting comprised the BHU in this municipality, located in southern Brazil. Initially, contact was established via e-mail with the Municipal Health Department (SMS). Following institutional approval, coordination with the BHU was sought to identify potential participants. Due to the lack of response from these entities, the snowball sampling strategy was adopted to select oral sources.

Participants and Eligibility Criteria

Inclusion criteria consisted of working as a clinical nurse in a BHU in the

municipality of Florianópolis, Santa Catarina, or having worked in the management of the PCC between 1997 (the year of implementation) and 2018 (the year the Nursing Protocol for Child Care Needs was established). Nurses who worked exclusively in unit coordination or who were on any type of leave during data collection were excluded.

The first participant interviewed was a professional recommended by the study supervisor, selected due to her extensive experience of more than 20 years working in child health care. The remaining participants were successively selected based on previous referrals. Thirty-five nurses were invited to participate; 15 accepted the invitation, four declined due to lack of time, and 16 did not respond to the initial contact. The final sample was defined by data saturation, which was observed at the 10th interview, resulting in a total of 15 participants to ensure the complementarity of the narratives.

The meetings with the professionals were conducted remotely via Google Meet® or Zoom®, scheduled in advance according to the participants' preferences and availability. Access instructions were sent via WhatsApp®, after they agreed to participate. There were occasional technical difficulties due to connection instability, which were resolved through pauses and resumptions, without compromising the content. The interviews recorded in both audio and video formats with verbal and written consent.

Data collection took place between September and November 2023 and was conducted by the main researcher, who has experience in child health care and PHC. Prior to data collection, a pilot test and qualification process were conducted with experts in child health, oral history, and PHC.

The interview guide was structured into two stages. The first consisted of sociodemographic and professional characterization, including data such as age, length of professional training, and period of employment in the municipal health care network. The second stage consisted of six open-ended questions developed from the perspective of Thematic Oral History and Eliot Freidson's theoretical framework[14,15]. These questions sought to retrieve the historical experience of nursing consultations in child health within the municipality's PHC setting, exploring the impact of the PCC as a landmark for clinical practice and for the integration of nursing into efforts to reduce childhood health issues.

Participants' perceptions of health issues among children aged zero to two years were investigated, as well as the guidance and interventions considered essential during the consultation. Finally, the interview guide addressed the main difficulties experienced in conducting child health consultations and the repercussions of prenatal care actions on

subsequent child follow-up in primary care.

Data Processing

The recordings were listened to in their entirety and transcribed using Microsoft Word®. Subsequently, the material underwent a transcreation process to adapt the oral language to written language while preserving the meaning and fidelity of the accounts. The transcripts were not returned to the participants for review.

Data Analysis

During the analysis stage, the files were organized and stored in folders on the main researcher's Google Drive® account. Furthermore, Bardin's Thematic Content Analysis was followed[17], comprising three phases: pre-analysis, material exploration, and processing and interpretation of the results.

In the pre-analysis phase, a preliminary and exhaustive reading of the textual material derived from the interviews was conducted to familiarize the researcher with the corpus and identify central ideas. ach interview was read in its entirety, and excerpts related to nursing consultations in child health, professional autonomy, the Capital Child Program, municipal protocols, guidance provided to families, and practices for monitoring child growth and development were highlighted as units of record.

During the material exploration phase, the documents were imported into ATLAS.ti 9® software, which supported the organization, coding, and retrieval of excerpts. Coding was performed manually by the main author based on a line-by-line reading of the accounts. Initially, descriptive codes were assigned to excerpts from the interviews, such as monitoring of growth and development, child assessment, family guidance, family bonding, nursing protocol, professional autonomy, referrals, vaccination, and comprehensive care. Subsequently, these codes were reviewed, compared according to thematic similarity, and grouped into clusters of meaning.

As an example of the analytical process, excerpts mentioning weight and height curves, vaccination follow-up, and physical assessment, including weight, measurements, and circumference, were initially coded as growth and development assessment, vaccination follow-up, and clinical assessment of the child. Subsequently, these codes were grouped into the meaning cluster "systematized child assessment" and linked to the category "Nurses' leadership: building bonds and autonomy in child health consultations." Similarly, excerpts

related to the use of the nursing protocol, medication prescription, test requests, and support for clinical decisions were coded as nursing protocol, professional autonomy, and problem-solving capacity and comprised the meaning cluster "technical-institutional support for nursing practice." The interpretation of these groupings was guided by Freidson's concepts of expertise, credentialism, professional autonomy, and professionalism.

During the processing and interpretation of the results phase, the meaning clusters were compared across interviews to identify convergences, recurring patterns, and singularities in the narratives. The analytical categories were defined after successive readings of the codes and excerpts, considering frequency, thematic relevance, and their relationship to the study objective. The interpretation considered the socio-historical perspective of the study[15] and was conducted in light of the socio-historical framework and Eliot Freidson's Sociology of Professions, particularly the concepts of expertise, credentialism, professional autonomy, and professionalism[14]. Thus, the accounts were analyzed not only based on the recurrence of themes but also on how they expressed the historical construction of nursing consultations in child health and the strengthening of nursing jurisdiction in Primary Health Care.

Freidson's Sociology of Professions theoretical framework[14] was used to understand nurses' professional autonomy and the construction of professionalism in child health care. From this perspective, expertise refers to mastery of specific knowledge, formalized and developed through the experience and knowledge production of a particular professional group; in this study, it relates to the clinical and care-related knowledge mobilized by nurses during child health consultations. Credentialism, in turn, refers to the institutional, legal, educational, and regulatory mechanisms that legitimize a profession and delimit its scope of practice, as observed in nursing through professional education, regulation by the professional council, and municipal regulations that guide child health care. Professional autonomy is understood as the relative capacity to control one's own work based on specialized knowledge and techniques, although conditioned by social recognition and state regulation. Professionalism, in turn, expresses the articulation among specialized knowledge, credentials, self-regulation, and ethical responsibility in professional practice[14].

Based on this entire theoretical framework, the analysis examined how the Capital Child Program and the municipal nursing protocol strengthened nursing jurisdiction in child health care by fostering the consolidation of nursing-specific knowledge, practices, and decision-making within Primary Health Care[5,11,14]. Coding was performed exclusively by the

main author to ensure consistency in the analytical criteria adopted in the study.

Ethical Aspects and Data Protection

The study was approved by the Research Ethics Committee of the *Universidade Federal de Santa Catarina* (CAAE 67769023.0.0000.0121; opinion no. 6,048,927/2023). Ethical principles were observed in compliance with CNS Resolution No. 466/2012 of and the Brazilian General Data Protection Law (LGPD). Given the socio-historical nature of the research, participants authorized the use of their statements and disclosure of their real identities through a copyright assignment letter and the Informed Consent Form (ICF).

The raw data (video/audio recordings) were stored on the main researcher's personal drive, in a study-specific folder protected by two-factor authentication and a strong password, with access restricted to the researcher and her supervisor. The files were stored separately from the analytical database, with an identification list maintained in a separate file, and the versions used for analysis were pseudonymized when applicable.

Following the preparation and verification of the textual material, the files were transferred to a computer at the research laboratory of the university with which the main author is affiliated to ensure institutional data storage. These files will remain stored for five years, in accordance with the protocol approved by the Research Ethics Committee. After this period, the digital files will be permanently discarded.

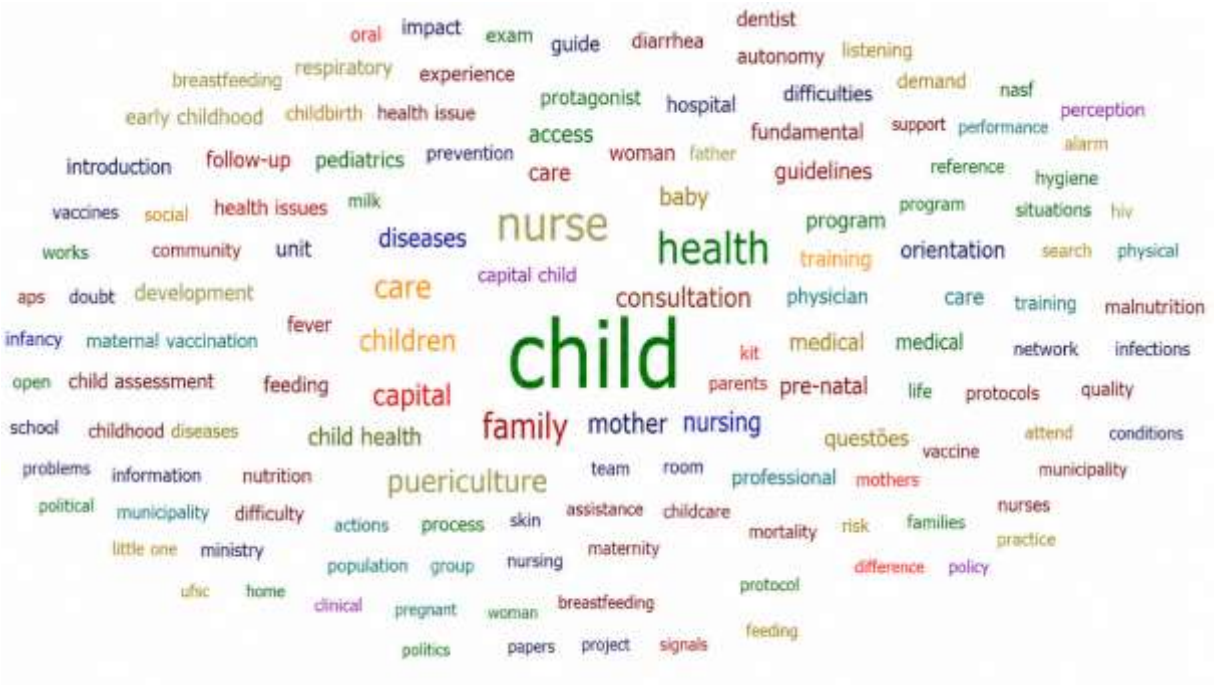
RESULTS

The oral sources for this study consisted of 15 nurses, aged between 34 and 72 years. The interviews lasted from 11 to 76 minutes, with an average duration of 35 minutes. Graduation years ranged from 1976 to 2013. Regarding the highest level of education, one nurse held a doctoral degree; six held master's degrees; seven had specialist-level qualifications; and one was pursuing postgraduate education. The year of entry into the labor market ranged from 1988 to 2013. Regarding length of employment in PHC, it ranged from eight to 30 years, while experience in child health care ranged from six to 30 years, with an average of 17 years.

After characterizing the participants' profiles, the textual corpus of the interviews was analyzed with the support of ATLAS.ti 9® software. This stage allowed for the identification of the most frequently occurring words in the analyzed material. The five most frequent words were: "child" (600 times), "health" (271 times), "consultation" (235 times),

"nurse" (213 times), and "family" (185 times). The frequency of these terms suggests their centrality within the corpus, as they are directly related to the study's overall objective and central theme, as illustrated in Figure 1, which presents the most prominent words. The word cloud was generated by the software as an exploratory visualization of the corpus, and the categorization was established through thematic analysis following coding.

Figure 1 – Word Cloud



Source: Adapted from ATLAS.ti version 9. 2025.

Ultimately, three categories were identified: 1. Nursing consultation in child health: childhood health issues; 2. Difficulties faced during nursing consultations in child health; and 3. The nurses' leadership: building bonds and autonomy in child health consultations.

Nursing consultation in child health: childhood health issues

From the nurses' perspective, the childhood health issues monitored during child health consultations vary according to the territory and the living conditions of families. This variation is related to frequent and seasonal events (especially respiratory conditions); health issues related to prevention and surveillance (vaccine-preventable diseases); conditions associated with nutrition and development; and situations marked by social and programmatic vulnerabilities.

In this context, nursing consultation is described as a space for identifying risks,

providing guidance to families, and preventing complications and health issues. In addition, noncommunicable health issues related to growth and development were mentioned, particularly low weight and impaired weight and height gain.

> *[...] we deal with all kinds of health issues, ranging from domestic violence to nutritional issues, which are the lack of food, deficiency, lack of education or lack of resources on the part of the parents.* (Cleusa)

> *The most common health issues are acute respiratory syndromes, even before COVID. [...] pneumonia and bronchiolitis were the most common. [...] there are noncommunicable health issues, such as low weight, low birth weight, and impaired growth and development.* (Indiana)

> *Thinking about health issues in children's lives and health, I still see issues related to social vulnerabilities [...]. Regarding the conditions tracked by SINAN, they are not so present in my practice today; I have worked in other situations, so throughout my career, I have encountered issues related to vulnerability, especially domestic violence and neglect, with many cases involving the Child Protective Services Council; [...] I think the biggest challenge and what I see as still being most problematic is early weaning, even though I emphasize the importance of breastfeeding in my consultations [...]* (Mariana)

Across the testimonies, respiratory issues and common infections were cited as significant parts of daily practice, with an emphasis on preventing complications and providing guidance to families.

> *Health issues that cannot be prevented, for example, URTI, there are some things we can do, but they are very common, and children will have respiratory tract infections, colds; there is no way around it, but we can prevent complications from a cold, such as otitis, among others.* (Meriane)

> *And what we really had most were infections, respiratory infections; gastrointestinal infections were less frequent, but they did occur. Diarrhea, vomiting [...]. So, there were several events that arose in everyday life, and we could provide guidance to the family.* (Vanessa)

Conditions requiring surveillance and reinforcement of immunization actions were also mentioned and were understood as areas particularly amenable to intervention in PHC.

> *At that time, vaccine-preventable diseases and parasitic infectious diseases were things we always had to reinforce; today as well [...]. Regarding respiratory diseases, we are in the South; today we have a very large variation in temperature, low temperatures, so in houses with large gaps that let in a lot of wind, we advised families to close them somehow, whether with fabric, some wood, or whatever.* (Márcia)

> *Well, my perception is that [...] they are vaccine-preventable; I think this is an area that is sensitive to primary health care, that is sensitive to nurses' actions, that is part of our role; I think vaccination is very much our responsibility, so there is this issue of*

> *the increase in respiratory diseases.* (Juliana)

Furthermore, the participants reported health issues associated with environmental exposures and dietary practices and highlighted child health consultations as an opportunity to provide guidance and implement preventive measures.

> *I think the most common health issues stem from allergies, both respiratory and dermatological; [...] so I think that the nursing consultation in child health is essential for providing guidance and managing these situations; it is an opportunity to provide initial guidance and reduce these potential allergens.* (Daniela)

Overall, the accounts show that the health and illness context of children followed in PHC includes frequent and vaccine-preventable health issues, as well as situations shaped by social vulnerabilities, requiring nurses to conduct clinical assessments, health surveillance, and educational actions as part of monitoring child growth and development.

Difficulties faced during nursing consultations in child health

The interviewees reported multiple difficulties in conducting nursing consultations in child health, including sanitary and structural conditions, socioeconomic vulnerabilities, barriers related to health literacy, as well as challenges to the continuity of care in PHC.

> *Thinking about health issues in children's lives and health, I still see issues related to social vulnerabilities [...]; cria children in situations of vulnerability or low income [...]* (Mariana)

> *[...] The difficulty lies in sanitary conditions, housing, and income. [...] So, I think that health issues in early childhood are linked to low vaccination coverage.* (Caren)

> *Some social issues, I think, are challenges, and not only those related to children, but social issues that ultimately end up being dealt with in health care. I have cared for children who were vomiting because they had eaten only apples all day, because there was nothing else to eat at home, and the apples had been obtained from some food distribution center. So, what treatment for diarrhea and vomiting can be provided to a child who has nothing to eat at home? I think there are some social issues that are more intense, more severe, and that reach us and leave us feeling powerless as health professionals [...]; there are also consultations with foreigners and people with disabilities, where the way we communicate is different for them. So, I think these are some of the factors that make care more difficult.* (Juliana)

Moreover, structural limitations and barriers to continuity of care were identified, such as difficulties in locating families and maintaining ongoing follow-up, particularly in contexts of greater social vulnerability.

> *Regarding the difficulties: physical infrastructure and supplies, depending on the period things would be missing [...]; often, patients experiencing greater socioeconomic deprivation live in socially vulnerable areas. They change their phone*

> *numbers frequently, there is constant turnover. Therefore, there is considerable difficulty in locating them; I think this is one of the major difficulties we face.* (Renata)

Another difficulty highlighted was resistance from the community and other professionals regarding nurses conducting child health consultations, with the persistence of physician-centered expectations and associations between "quality" and medical care, affecting confidence in and the social and institutional recognition of nurses' work.

> *[...] I feel that the main difficulty is the appreciation of nurses as professionals. [...] Often, this prejudice does not come only from users; it also comes from professionals from other teams, especially when we talk about care; [...] we hear professionals telling mothers that they have to go to the health center and demand to be seen by a pediatrician, that the person who is going to care for a child, and who cares for children, is the pediatrician, not the nurse.* (Indiana)

> *[...] there was still difficulty in the community's understanding and recognition of the nurse's role in care. There was still a great deal of resistance, partly because child care was centered on the pediatrician [...]* (Márcia)

> *I think that, in the beginning, accepting a nurse was always associated with the idea of being subordinate to the physician. "Oh, if they had studied more, they would have become a physician." So, I think this is indeed a problem that is still faced today. [...] You realize that the father or mother does not trust the care you provide.* (Angélica)

> *[...] regarding the resistance of some people to recognizing nursing as a profession capable of providing individualized, high-quality care, there is a need to recognize that receiving care from a nurse does not mean a loss of quality — "Oh, you are going to see the nurse, and the consultation will be worse than if you saw a physician..." I think the first issue is precisely this recognition that, yes, you will be seeing a nurse because, for certain situations, the nurse is the best professional to provide that care. I think this recognition is something that still needs to be built; we are part of that process, and so are our colleagues. I think that, within the team, we also have the role of winning others over and showing our potential to our colleagues so that they can reinforce this with service users as well.* (Juliana)

In addition, initial insecurity regarding the clinical management of children and in conducting consultations was mentioned, associated with perceived gaps in clinical education and the need for continuing education and professional practice over time. These gaps were associated with difficulties in conducting safe clinical assessments of children, including aspects of child health care.

> *Many times, we also graduate lacking some knowledge, particularly regarding physical examination of children [...]. When I started practicing, I felt very insecure and afraid of making mistakes, so I would call the physician to check everything I did, even so that I could feel more confident. So, I think this is a problem; [...] nurses who are being trained today do not graduate with autonomy and knowledge [...]* (Angélica)

> *[...] I think there is a major deficiency in the clinical training of nurses to conduct nursing consultations and perform a proper physical examination; [...] well, there is this deficiency originating in university education, and then it depends a lot on each*

> *professional seeking further qualification [...]* (Juliana)

> *At the beginning, I had somewhat more difficulty handling the child, because it is not easy, but over time we gained experience and learned how to deal with children and develop the consultation process.* (Indiana)

Finally, institutional support through nursing protocols was identified as a facilitating strategy, while length of professional experience and specialization in child health care may increase the safety and effectiveness of nursing consultations.

> *The lack of clinical protocols, back then... in certain situations we faced... We have them now; today, I am satisfied with the protocols we have in the municipality [...]* (Juliana)

The nurses' leadership: building bonds and autonomy in child health consultations

Nurses' leadership in child health consultations was associated by the participants with a comprehensive, child- and family-centered approach, supported by bonding, welcoming care, and active listening, combined with technical-scientific competencies to identify risk situations, provide guidance, prevent health issues, and coordinate follow-up within the territory.

> *The main characteristic is the nurse's humanized and transcultural perspective, the focus on the family. So, this is the main characteristic, because the nurse is a professional who, in their training... They are not trained for biomedical care; they are trained for comprehensive care; they look at the person as a whole; they are the professional who will look at the entire support network of the child. In this, the nurse is a protagonist, in addition to the issue of access. Access to the nurse is much easier; the bond with the nurse is stronger than with a medical professional.* (Indiana)

> *[...] nurses play a leading role due to their training, they have this broader perspective, because we are more available to listen and welcome; that is part of our training. We have scientific training within our curriculum that allows us to provide more specialized care to a child, to a pregnant woman [...]* (Márcia)

> *The consultation is a method, a work instrument of nursing, and an activity that is still exclusive to nurses under our professional practice legislation, in which the principles of the nursing care process are applied. It is a method of providing care; and it is during the consultation that you can identify higher-risk situations, establish a bond with the family, the mother, the caregiver, and the child. Furthermore, the consultation allows you to provide guidance on care and explain prevention strategies.* (Márcia)

In addition, the participants highlighted nurses' leadership in the systematized assessment of child growth and development, with monitoring of clinical markers and educational actions throughout follow-up, including guidance related to child care and vaccination schedules.

> *[...]in the following years, the focus was on child growth and development... neuropsychomotor development... it was crucial to plot weight and height on growth charts and monitor vaccinations.* (Vanessa)

> *[...] not only the physical assessment, weight, measurements, and circumference, but also guidance... The nursing consultation is very comprehensive…* (Caren)

Another aspect reported was the expansion of professional autonomy and problem-solving capacity following the institutionalization of nursing protocols, which provide support for clinical decisions, strengthen clinical confidence, and facilitate management during consultations.

> *I see the protocol as providing us with autonomy in this care, and that is where leadership comes in, because, in general, the person who will provide the care, who will assess and look after the child, is the nurse, who is there on a more day-to-day basis. These consultations are generally nursing consultations. [...] I think leadership is built around the protocol [...] The vaccination room, which is also part of nursing, a room that is ours.* (Caren)

> *[...] with the introduction of the Protocol in 2018, care improved considerably. Simply because you can prescribe medications and request tests, you increase your autonomy and empowerment. And, regarding the physical examination; you feel much more confident because [...] the protocols here are a distinguishing factor in this care because they provide greater autonomy and support, thereby expanding the actions we can take for that family and that child.* (Angélica)

The bond established during prenatal care was described as an element that facilitates continuity of follow-up in child health consultations, expanding access to and adherence to follow-up in PHC. It was also emphasized that child health consultations involve a commitment to ensuring that families understand the guidance provided, building bonds, and recognizing the families' living context and culture, thereby expanding the possibilities for interventions aimed at reducing health issues.

> *[...] nurses should have a clear understanding of what child health care is and the importance of this consultation, as well as a commitment to the mother to make sure that she understood all the guidance you provided. And, most importantly, to build a bond with this mother so that she has someone to turn to whenever she needs assistance within the health center; [...] we nurses are capable of conducting a child health consultation in order to get to know the family; today, compared with 20 years ago, we can understand where they come from, where they live, what their context is, what their culture is, and where I can intervene to reduce the health issue.* (Cleusa)

Regarding the socio-historical and programmatic dimension, the interviewees identified the PCC as a milestone in 1997, which contributed to the organization of maternal and child health care in the municipality, both through coordination between maternity services and PHC and through its impact on the structuring of the first consultations and guidance during the neonatal period.

> *[...] when the Capital Child Program was introduced, practice changed a lot... it strengthened child health care... the Capital Child Program ultimately became the link with the maternity service...* (Indiana)

Finally, nurses' leadership was associated with their role in coordinating care within the health care network and territory, with active follow-up of children, strengthening bonds with families, and actions aimed at ensuring rights.

> *[...] it is the nurse's role to be attentive to each child in the territory, to ensure that rights and health care are guaranteed, including children's and adolescents' rights [...] Building a bond means knowing that, for that family, you are a reference point; that the mother will seek out the health professional; and, speaking specifically about the nurse, she is a source for answering questions and providing appropriate information.* (Mariana)

DISCUSSION

The health issues in children monitored by nurses during child health consultations were diverse and heterogeneous and varied according to the territory, living conditions, and social circumstances of families. Although social vulnerabilities are more pronounced in certain contexts, the accounts indicate that, regardless of the health unit, respiratory tract infections are a recurrent health issue. These findings are consistent with the literature, which simultaneously identifies frequent health issues in everyday life and problems related to social inequalities, such as domestic violence, malnutrition, early weaning, low weight, vaccine-preventable diseases, and allergies[3,18]. Thus, discussing the health/disease context of children requires recognizing that health issues cannot be explained solely by biological factors but also by the social determinants of the illness process, making interventions addressing potentially modifiable determinants, such as education, health literacy, living conditions, and caregiving practices during the first year of life, particularly important [3,18].

In this context, nurses' leadership in child health care emerges as a situated and historically conditioned construct: it is strengthened when there is organization of the work process, institutional support, and integration of the health care network; however, it is weakened when social and programmatic barriers predominate. The participants described nursing consultations as a space for risk identification, guidance, prevention, and mediation of health care, supported by technical-scientific competencies and a broader perspective of the child and family. These elements are consistent with the biopsychosocial model and a comprehensive care approach, in which bonding, welcoming care, and active listening are articulated with growth and development surveillance, immunization, and educational actions

aimed at health promotion[9,12].

According to the accounts, health education (guidance on breastfeeding, nutrition, and immunization) is a constitutive component of nurses' practice in child health care, with the potential to reduce complications and health issues. At the same time, the difficulties in conducting nursing consultations in child health express limitations that extend beyond the clinical encounter and are linked to the way public policies and institutional arrangements have historically materialized in everyday PHC practice. The interviewees identified obstacles related to sanitary and structural conditions, low income, illiteracy/reduced health literacy, and language barriers, factors that compromise continuity of care and reinforce inequalities in access and longitudinal follow-up[7,18].

Beyond individual aspects, these elements should be understood as expressions of broader and persistent social processes: precarious living conditions, urban inequalities, and contemporary challenges in the health system's response to vulnerable populations.

From a socio-historical perspective, the discussion of child morbidity and mortality also shifts from an exclusively clinical interpretation toward an understanding of historical changes in social protection policies, the epidemiological profile, and the health system's capacity to respond to risks and vulnerabilities. Preparing professionals for competent care depends not only on technical knowledge but also on the ability to analyze socioeconomic and cultural factors in conjunction with the physical and psychosocial conditions that influence child development[19]. Thus, the accounts suggest that, in more vulnerable territories, child health care requires nurses to integrate clinical practice, health surveillance, and educational actions, often in the face of needs that exceed the scope of strictly clinical interventions.

Furthermore, regarding the social and institutional recognition of nursing work, the findings indicate resistance from the community and other professionals to child health consultations conducted by nurses, signaling the persistence of a biomedical and physician-centered culture. This devaluation and limited visibility cannot be understood merely as individual opinions, but also as expressions of the historical division of labor in health care and the hierarchy of professional knowledge. This hierarchy may confer greater legitimacy on medical care and reduce the visibility of nursing in child health care[14,20,21]. Although the study demonstrates nurses' autonomy, skills, and dedication in child health care, the challenge remains to strengthen professional attributes such as expertise, autonomy, and credentialism, from professional education through entry into the labor market, in order to consolidate social and institutional legitimacy in child health care[14,21,22].

Another significant finding was the clinical insecurity reported by some nurses when managing children, associated with gaps in training and the need for continuous professional development. This scenario is consistent with generalist nursing education and reinforces the relevance of continuing education and specialization, particularly to strengthen clinical assessment and confidence in clinical decision-making during consultations[3,20]. At the same time, the literature indicates that nurses' role in child health care has gained increasing relevance, with professional maturation and deeper knowledge in specific areas, which has implications for the quality of care and the consolidation of their role in PHC[3,10,19].

Within the sociology of professions, specialized knowledge is central to professional autonomy and recognition of professional work. From this perspective, Freidson's contributions help interpret leadership as the result of a social arrangement in which the profession sustains its field of practice through expertise, legitimacy, and capacity for self-regulation[14].

The active pursuit of technical-scientific support, legislation, public policies, and nursing protocols strengthens nurses' autonomy in child health consultations, increases problem-solving capacity and professional visibility, and contributes to qualified, specialized care grounded in the science and technology of care[5,8,20-24].

Professional autonomy, from Freidson's perspective, relates to relative control over one's own work, supported by specialized knowledge, professional credentials, and recognition of the profession's jurisdiction[14]. In this sense, when nursing appropriates child health consultations supported by technical-scientific foundations, it is anchored in specialized knowledge rather than in the mere delegation of tasks. In nursing, autonomy is also expressed through legal and regulatory provisions governing professional practice and providing support for care practices[20,21]. However, this autonomy encounters obstacles related to the bureaucratic structures of the health system and the persistence of physician-centered ideologies that challenge the legitimacy of nursing in child health care.

In Florianópolis, the accounts regarding the PCC as a historical milestone provide an understanding of how the institutionalization of care pathways, routines, and coordination between maternity services and PHC can facilitate access, continuity of care, and educational actions during the neonatal period, ultimately contributing to the reduction of health issues[5,11]. Thus, nurses' leadership emerges not only as an individual attribute but also as the result of historical and institutional conditions that may strengthen or limit child health care practice in PHC.

Study limitations include the small sample size, comprising 15 nurses from a single municipality in southern Brazil, which may restrict the transferability of the findings to other PHC contexts. In addition, because oral sources were used, the results may have been influenced by recall bias and by the participants' involvement in child health care and in the trajectory of the PCC, since some were involved in its implementation and/or acted as program reference professionals. Future studies should expand the settings and participants involved (including other regions, professional categories, and family members) and incorporate complementary approaches, such as documentary analysis, to deepen the understanding of the development of nurses' autonomy and leadership in child health care.

FINAL CONSIDERATIONS

This socio-historical study analyzed nurses' role in child health consultations in PHC within the context investigated and highlighted a practice that integrates a holistic perspective, clinical assessment, monitoring of growth and development, health surveillance, health education, and care coordination.

From Eliot Freidson's perspective, these elements reflect the mobilization of nursing-specific expertise, supported by technical-scientific knowledge, professional experience, and responsibility for providing child health care. From this perspective, nursing consultations in child health are not limited to task performance but involve clinical judgment, decision-making, and organization of care based on profession-specific knowledge. The findings indicate that, in the face of frequent health issues, respiratory conditions, and conditions related to immunization, nutrition, and development, nursing consultations constitute a space for identifying risks, providing guidance to families, and preventing complications.

At the same time, the narratives revealed that this practice is challenged by social vulnerabilities, health literacy barriers, structural limitations, difficulties in ensuring continuity of care, and physician-centered resistance. From a Freidsonian perspective, these tensions reveal disputes surrounding professional jurisdiction and the social and institutional recognition of nursing in child health care.

Thus, nurses' leadership and autonomy in child health care are configured as relative, historical, and continuously developing processes. In the municipality studied, these processes were strengthened by professional expertise, institutional support, and work organization, driven by milestones such as the Capital Child Program and the

institutionalization of nursing protocols.

The findings point to the need for continuing education strategies, improvement of clinical training, and intersectoral actions aimed at contexts of greater vulnerability, in order to improve child health care in PHC and strengthen the legitimacy of the nursing role in child health care.

REFERENCES

1. Albernaz ALG, Couto MCV. Childcare in the Brazilian Unified Health System: child care from the perspective of comprehensive health care. Saúde Debate. 2022;46(spe5):236-48. https://doi.org/10.1590/0103-11042022E519
2. Ministério da Mulher, da Família e dos Direitos Humanos (BR). Estatuto da Criança e do Adolescente: Lei nº 8.069, de 13 de julho de 1990 [Internet]. 2021 [cited 2025 Jun 19]. Available from: https://www.planalto.gov.br/ccivil_03/leis/l8069compilado.htm
3. Reis KGL, Serranegra NVF, Varela ALV, Almeida PA, Carrer MO, Barreto CP, et al. Child health nursing consultation and competencies for Advanced Practice Nurses. Rev Esc Enferm USP. 2024;58:e20230269. https://doi.org/10.1590/1980-220X-REEUSP-2023-0269pt
4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Cadernos de Atenção Básica. Saúde da criança: crescimento e desenvolvimento [Internet]. 2012 [cited 2025 Jun 19]. Available from: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/s/saude-da-crianca/publicacoes/saude-da-crianca-crescimento-e-desenvolvimento-ministerio-da-saude-secretaria-de-atencao-a-saude-departamento-de-atencao/view
5. Prefeitura Municipal de Florianópolis. Secretaria Municipal de Saúde. Protocolos de enfermagem [Internet]. 2022 [cited 2025 Jun 19]. Available from: https://www.pmf.sc.gov.br/entidades/saude/index.php?cms=protocolos+de+enfermagem&menu=10&submenuid=1478
6. Secretaria de Estado da Saúde de Santa Catarina. Plano Estadual de Saúde 2024–2027 [Internet]. 2023 [cited 2026 Feb 12]. Available from: https://www.saude.sc.gov.br/edocman/areas-de-atuacao/planejamento-em-saude/plano-estadual-de-saude/plano%20estadual%20de%20sa%C3%BAde%202024-2027.pdf
7. Vieira DS, Soares AR, Lucena DBA, Santos NCCB, Nascimento JA, Reichert APS. Factors that influence the practice of nurses in childcare consultation in primary care. Rev Baiana Enferm. 2023;37:e51023. https://doi.org/10.18471/rbe.v37.51023
8. Conselho Federal de Enfermagem (COFEN). Resolução COFEN nº 736, de 17 de janeiro de 2024: Dispõe sobre a implementação do Processo de Enfermagem em todo contexto socioambiental onde ocorre o cuidado de enfermagem [Internet]. 2024 [cited 2026 Feb 12]. Available from: https://www.cofen.gov.br/wp-content/uploads/2024/01/Resolucao-Cofen-no-736-2024-Dispoe-sobre-a-implementacao-do-Processo-de-Enfermagem-em-todo-contexto-socioambiental-onde-ocorre-o-cuidado-de-enfermagem.pdf
9. Rojas CFN, Pio DAM, Nonato AC. Understanding child development and care integrality: Primary Health Care doctors and nurses' view. Rev Paul Pediatr.

2024;42:e2023127. https://doi.org/10.1590/1984-0462/2024/42/2023127

10. Fernandes Carvalho M, Trigueiro JG, Freitas RJM, Bessa MM, Souza JO, Lima LS. [Nurses' actions in childcare Nursing consultations in Primary Care]. Enferm Glob. 2024;23(73):296-308. https://doi.org/10.6018/eglobal.573201 Portuguese

11. Coelho RC, Santos EK, Tavares AM, Tobias LT, Fischer Júnior R. Programa Capital Criança: resgatando a cidadania. Florianópolis: Insular; 2004. 192p

12. Martins AT, Freitas VF, Castro LC, Andrade TIX, Ferreira WV, Gesteira ECR. Nursing consultation in childcare in nurses' and managers' voices: a mixed methods study. Rev Bras Enferm. 2025;78(4):e20240657. https://doi.org/10.1590/0034-7167-2024-0657pt

13. Bousfield APS, Padilha MI, Bellaguarda MLR. Autonomy in acupuncture practice by nurses in southern Brazil (1997-2020). Esc Anna Nery. 2025;29:e20240096. https://doi.org/10.1590/2177-9465-EAN-2024-0096pt

14. Freidson E. Renascimento do profissionalismo: teoria, profecia e política. São Paulo: Editora da Universidade de São Paulo; 2019. 288p

15. Padilha MI, Bellaguarda MLR, Nelson S, Maia ARC, Costa R. The use of sources in historical research.Texto Contexto Enferm. 2017;26(4):e2760017. https://doi.org/10.1590/0104-07072017002760017

16. Souza VRS, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. Acta Paul Enferm. 2021;34:eAPE02631. http://doi.org/10.37689/acta-ape/2021AO02631

17. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016. 288p

18. Munhoz TN, Santos IS, Blumenberg C, Barcelos RS, Bortolotto CC, Matijasevich A, et al. Factors associated infant development in Brazilian children: baseline of the impact assessment of the Happy Child Program. Cad Saúde Pública. 2022;38(2):e00316920. https://doi.org/10.1590/0102-311X00316920

19. Moura GR, Mazza VA, Ruthes VBTNM, Vicente JB, Kaufmann GW, Dezoti AP. Nurses' practices in caring for children in Primary Health Care: an integrative review. Rev APS [Internet]. 2025[cited 2025 Jun 19];28:e282544461. Available from: https://periodicos.ufjf.br/index.php/aps/article/view/e282544461

20. Alvarenga J da PO, Sousa MF. Work and practices of nursing in Primary Health Care in the state of Paraíba – Brazil: professional profile and care practices in the care dimension. Saúde Debate. 2022;46(135):1077-92. https://doi.org/10.1590/0103-1104202213509

21. Bellaguarda ML dos R, Queirós PJP. Nurse autonomy expressed in Portuguese and Brazilian professional legislation: a documentary study (1986–2022). Rev Esc Enferm USP. 2023;57:e20230199. https://doi.org/10.1590/1980-220x-reeusp-2023-0199en

22. Franco ACR, Penido CMF. Co-production of autonomy in Primary Health Care. Saúde Soc. 2025;34(1):e240363pt. https://doi.org/10.1590/S0104-12902025240363pt

23. Toso BRG, Orth BI, Vieira LB, Nora CRD, Geremia DS, Mendonça AVM, et al. Practices developed by nurses in primary health care in southern Brazil. Rev Gaúcha Enferm. 2024;45:e20230154. https://doi.org/10.1590/1983-1447.2024.20230154.en

24. Soares AR, Vieira D S, Guedes ATA, Brito PKH, Andrade ME, Correia ASB, et al. Child Health Handbook in Primary Care: perspectives of family health professionals and mothers. Rev Gaúcha Enferm. 2025;46:e20240022. https://doi.org/10.1590/1983-1447.2025.20240022.en

Data and material availability
Access to the dataset is available upon request from the corresponding author.

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