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Child care and health rights: perspectives of adolescent mothers*

O cuidado da criança e o direito à saúde: perspectivas de mães adolescentes

El cuidado del niño y el derecho a la salud: perspectivas de madres adolescentes

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ABSTRACT

Objective: To analyze child health care and the defense of their rights from the perspective of adolescent mothers. **Methods**: An exploratory study with qualitative thematic analysis of data, based on conceptual aspects of care and the right to health, from semi-structured interviews with 20 adolescent mothers ascribed by Family Health teams. **Results**: Maternal reports indicate that child health care requires responsibility and protection, with health practices that promote child advocacy. Gaps in assistance which preclude the full guarantee of the right to child health care were also highlighted. **Conclusion:** The right to health care assumed different meanings, and the forms to guarantee them were linked to individual behavior in detriment to broader actions that consider health as a social product, connected to the guarantee of other fundamental rights.

DESCRIPTORS

Child; Adolescent; Right to Health; Pediatric Nursing.

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INTRODUCTION

In providing healthcare for children, it is essential to focus on their essential needs[1] and to identify vulnerable situations in the face of adverse conditions for its development[2-3]. An expanded look into child care is also of utmost importance, taking into account the weaknesses for their own protection and defense[4], which require the presence and involvement of those who are engaged in advocating for ensuring their rights[5].

International concern about children's rights emerged in the late nineteenth century, with a global movement for the protection of children's rights[6]. Under the recognition of children's rights, the International Convention of Children's Rights was considered a legal frame of reference[6], and brought forth principles contained in the 1988 Federal Constitution of Brazil (art. 227) and the Statute of Children and Adolescents (*Estatuto da Criança e do Adolescente* -ECA) of 1990.

According to the paradigm of full protection, children and adolescents are considered subjects who hold rights, because they are in peculiar conditions of development, need special attention and protection, and should be top priority of the state, society and family[7]. From a formal point of view, Brazil has social programs and specific laws such as legal protection mechanisms and support for the most vulnerable groups. However, there are still social segments that do not even know their rights or the mechanisms that ensure them.

A delicate, complex and unique situation occurs when a child's mother is a teenager. The understanding of being a teenager must be based on a systemic and constructivist vision of the adolescent process, since adolescence is the period that requires special attention and protection[8]. Motherhood in adolescence also requires the presence of trained professionals to identify and meet the demands of the teenage mother and child beyond the biological dimension, aimed at promoting health and quality of life, maternal empowerment and realization of teen and children's rights[9-10].

The guarantee of the right to child healthcare refers to the need for integrity in the care and empowering caregivers and families through the construction of knowledge and strengthening of skills and abilities relating to the care and defense of attitudes, where this professional plays the role of facilitator and mediator, seeking to promote and guarantee the right to health[5,11]. Studies have also emphasized the importance of knowledge of rights by persons related to the capacity of care and self-care[12], understanding the child as being entitled to rights[6], to the way rights are recognized by the families[13] and its benefits for clinical practice[4].

In the context of defending healthcare rights in childhood, it is relevant to know the perspectives of adolescent mothers and those that relate to the rights of their children healthcare, in the search for support of comprehensive care and strengthening families in their attitudes towards defending their health. Thus, this study aimed to analyze the health care of children and the defense of their rights from the perspective of adolescent mothers.

METHOD

An exploratory study with qualitative data analysis, based on conceptual aspects of care and the right to health[14-15], according to the *Consolidated Criteria for Reporting Qualitative Research* (COREQ)[16].

The research was conducted in the municipality of Passos, MG, Brazil, with the participation of 20 adolescent mothers ascribed by teams operating in the Family Health Units (*Unidades de Saúde da Família* - USF). For selection, the 17 existing USF in the municipality were arranged in a sequence of descending order according to a study of the number of teenage mothers registered in the period from 01/01/2012 to 31/12/2013.

Inclusion criteria were: mother aged between 12 and 18, having a child aged between six months and less than two years old, being registered and monitored by the USF team. Exclusion criteria were: interruption of monitoring the child's health in the selected USF, moving away from the USF coverage area, the mother having mental health problems, or not contact at home after three attempts at different times.

The instrument developed for data collection was refined through pilot testing. Data collection was conducted by the first author in January and February 2014 and followed the following steps: researchers attended the selected USF; they collected a list of names and addresses of ascribed adolescent mothers that met inclusion criteria, with the assistance of Family Health Team members (*Saúde da Família* - SF); they visited the home of adolescent mothers in the company of a Community Health Agent (*Agente Comunitário de Saúde* - ACS); they approached teenage mothers through home visits and conducted individual semi-structured recorded interviews. During the visits, the objectives and procedures of the research were explained and, if the legal guardian allowed the adolescent mother's participation and she agreed to participate, consent forms were read and signed. The same procedures were adopted for all participants of the 17 selected USF until theoretical saturation[17], being the 20th interview. There were no refusals to participate in research.

The semi-structured interviews were conducted in a single meeting, lasting 40 minutes to an hour, with encouragement of free-form statements, using the following as a starter question: How has it been caring for your child since birth? From that question, their reports of everyday situations, perceptions of child protection and safety and child health practices were encouraged, which allowed for the adolescent mothers to narrate the care of children with emphasis on protection of health.

The qualitative data analysis was designed based on inductive thematic content analysis[18]. From this inductive model, the identified themes were extracted from the data and a coding process was conducted from the data, do not fixed *a priori*, meaning that they were based on the data itself[18]. The codification process was guided by repetitive readings of collected data, identifying significant situations and the regularity with which they appeared in interviews, analysis of the meanings, elaboration and discussion of the

issues. It is worth mentioning that no computer programs have been used to manage data.

The research obtained approval from the Research Ethics Committee, opinion No. 507,936, CAAE: 21800413.9.0000.5112, and followed the recommendations for research on human subjects, using an Informed Consent and Agreement Form.

RESULTS

In a general characterization of the 20 study participants, it is emphasized that the age ranged from 15 to 18 years, nine had not completed high school, 10 were single, 10 had a family income of up to one minimum wage, 17 had one child and 12 children were younger than one year old. With regard to child care, 17 teenage mothers relied on help from others, with emphasis on the maternal grandmother of the child, as reported by 14 mothers.

The results were grouped in the following thematic units: Living in health: responsibility, protection and rights; Health care practices for the defense of children; Gaps in guaranteeing the right to child health care.

Living in health: responsibility, protection and rights

In the reports from mothers, positive aspects of the children's well-being are noticed, establishing an interface between the right to health and absence of disease; also pointing to the importance of family responsibilities.

> *I think that, it is them not getting sick, living in health, and that this is very good! A sick child is very bad, the mother suffers with them, the family suffers* (E12).

> *I think they have the right to live in health, which is their own right. The family can try their best so they are healthy. (...) Taking care of them right, going to doctors, taking them for weighings, taking them to the doctor when they are a little sick, not medicating them without medical advice* (E10).

A comprehensive look on the right to child health, linking it with the protective care, with emphasis on promoting healthy eating and ensuring a safe environment can be evidenced in the statements:

> *I think about everything, so, for my children to have the right to health care, I believe we have to take care of them properly, taking proper care, looking after them so nothing bad will happen, so they don't hurt themselves. (...) You have to take care because health is everything* (E9).

> *I think it is their right, we have to do everything possible for them to be healthy children. (...)By giving them better food, giving them plenty of healthy things for them to live healthy* (E20).

The right to health was also represented as a social right that should be exercised by every child, given their fragility. Therefore, mothers indicated concern about the quality of services and professionals in health care, including their readiness and prioritization of children in care because of their fragility, as mothers themselves do.

> *I believe that every child has the right to live healthy. (...) And to guarantee this right I think that we need to have more quality doctors* (E18).

> *I think that their right to health is like this, if they gets sick, I think they have the right to a place to be seen as soon as possible because they are young and their health is weaker* (E5).

> *I think it is their right, of course, they have to live healthy. (...) To ensure them this right we need to take care of them, and I do, I believe that I take care of her very well. When she has something I always take care of her, I look for help at the health unit [USF]. I live for her, she's a priority for me* (E17).

Health care practices for the defense of children

Health practices and professional actions in USF visited by adolescent mothers are favorable, in a way, to exercising the protection of children's health, according to the needs and vulnerabilities found.

> *The Family Health Program (PSF) staff paid good attention to him, they contribute greatly to his health. (...). By weighing them we know how the child is, if they are underweight, what needs to be done to improve it, if they're fat, if they're thin. (...) The nurses give us guidance. (...). At the Family Health Program (PSF) the service is like this. One day I saw the nutritionist too, he gave me a paper with some things I had to give to my son, because he was almost underweight. We see the nurse, and if needed, we are referred to the doctor and the nutritionist* (E13).

Home visits are another practice appointed by adolescent mothers, with the possibility of defending attitudes by the team members. This is highlighted by the ACS, which accompanies them regularly, identifying vulnerabilities for the child's health, such as inadequate nutrition, or symptoms of disease, seeking to guide the mother, encouraging her to protect their child's health:

> *The PSF staff visits me here at home. Almost every week the girls [ACS] come here to the house to see how he is, they let me know about vaccine campaigns, they are always coming here, informing, guiding. (...) When he has a cold or is sick, they instruct us to go to the [USF] unit for a consultation, to see what he has, to prescribe the right medicine; they help a lot* (E15).

> *Now that she is growing, she is refusing to eat things, she only likes bean broth. The agent [ACS] said I have to take her to the nutritionist to check that, because she has to eat other foods, she cannot only have been broth* (E20).

Defense attitudes exercised by health professionals working in hospitals environments were also identified, emphasizing the importance of recognizing the needs of the child with promptness, access and specific attention; especially due to other less attentive professionals or inappropriate care to the child's situation:

> *When she had respiratory arrest, she was in pediatrics and a doctor was looking after her. I told the doctor that she was quiet, that she was not well. The doctor waited until my daughter had respiratory arrest inside the Santa Casa. Then, another doctor came, who is the pediatrician I still see today. He came and said that she had to go to the ICU, that pediatrics was no place for her to stay and he did not know what she was doing there. Because if she had stayed in pediatrics, the staff would not be able to take care of her. He helped me a lot at that time. This pediatrician follows her up, tells me what she can or cannot do, he really guides me, gives me confidence. (...) If it wasn`t for him, I would have lost her* (E11).

Gaps in guaranteeing the right to child health care

The statements from the mothers indicate gaps that occur during prenatal care and in the follow up/care of child development and growth, showing certain weaknesses in ensuring the right to health in childhood.

In the case of a pregnant adolescent, the uptake for prenatal care can be difficult, given that some adolescents, whether from insecurity or fear of the reaction for example, hide the pregnancy from their parents, delaying the start of monitoring:

> *I did not have prenatal care. When I told my mother I was pregnant I was already five months in. Then, I had two ultrasounds. And I had her at seven months.* (E11).

When the attention of the professional is restricted to the child's physical evaluation and without establishing proper communication with her mother, she does not identify a protective action by the professional.

> *I get there, the nurse take notes, lays her down, measures her, her size [length], her head [head circumference], here in the chest [girth], and then weighs her (...). But they do not give any guidance; they just say if the weight is normal or not.* (E4).

> *I take her to the PSF for follow-ups, for weighing, measuring. (...) I had to take her in the second week of February, but she is in day care, so I couldn`t take her* (E12).

The difficulty of access to care, tests and medicines points to the weaknesses of the local health system, which exposes children to different situations of vulnerability:

> *It is very rare that the USF doctor will see the child, she sends them to the pediatrician. And pediatricians are hard to find. Upstairs [in the clinic] it is very difficult to get a number for the pediatrician. Every time you go there, either there are no more numbers left, or the doctor is absent. Every time is the same. (...) Many people are waiting to see the pediatrician and there isn't room for everyone. So, there are always children who will not be seen, needing care (...). Once, my daughter had a sore and swollen throat, she had a high fever and even then I could not get an appointment. Then I had to take her to the Emergency Room* (E20).

> *He had heart murmurs (...). The examination [echocardiogram], if we were waiting for SUS we would still be waiting, we had to pay. (...) Even to schedule an exam is complicated. The two tests he did were paid for, because if my husband and I had to pay, we could not afford it. (...) It's been seven months now that the examination was requested and we do not have a date yet. (...)The first consultation with the children's cardiologist we paid for because it would take too long. We requested the SUS appointment when he was a month old and got it at four months. (...) So, there is a lot that is left out and that has to improve, to proceed, to look at the child* (E5).

> *Medication too, you want to go there to pick up a vitamin, something like this, they don't have it or it is out. They ask you to go on Friday, you go and what arrived is out, nothing left. Same thing, she has an allergy, it's like an allergy, every time I go for the ointment that she needs they don't have it* (E3).

Another aspect questioned by mothers is related to the communication of the guidelines and health recommendations, with little or no clarification by health professionals:

> *Yesterday, I took her to an appointment with the pediatrician. Then he asked me to observe her tongue, he did not say why, just told me to watch it. I asked why and he said, 'Only check it for me.' He told me to keep an eye if her tongue would fold like this [shows with her own tongue]. (...) I was worried, I thought it might be because of speech, but she speaks, she already says 'mom,' 'dad'* (E4).

DISCUSSION

In this study, exercising the right to child health was heterogeneously represented by the interviewed adolescent mothers. We found aspects related to the responsibility of the mother and the family for health promotion and child protection, the attitudes of healthcare professionals who contribute to the defense of children's health, as well as the recognition of gaps in the care network to children's health in the city studied, which can often undermine the exercise of the right to health care in childhood. The fact that none

of the respondents mentioned the Board of Commissioners of the public health units as being an expected example in the Organic Law of Health in Brazil to present their suggestions and complaints about the operation of services is also noteworthy.

The statements of the mothers did not directly relate to children's right to health care in to existing legislation and the role of the state in ensuring this right. The right to health was linked predominantly to the actions of health services, and maternal and family care. Intersectoral action, recognizing the breadth and complexity of health-illness, as well as the formation of partnerships between health services and families were not mentioned by these mothers in the context of the right to health in childhood. These features suggest certain limits in advocating for children's health.

Thus, we note that the statements showed naturalized conceptions of health and the health care actions circumscribed to curative care in cases of illness, although there was also mention of health promotion, especially regarding healthy eating and constant observation of the child. Similarly, the gaps that make it difficult to guarantee the right to children's health have also been restricted to individual behavior and attention of professionals or families.

It is worth reflecting that in the context of the Unified Health System (SUS), health is seen as a universal right that should be guaranteed by the State, acknowledging its social determinants and relating it to quality of life[11,19]. Therefore, it is necessary to point out that the right goes beyond the existence of laws and the state monopoly, being a social construction process[11]. Thus, guaranteeing the right to children's health requires the participation of various social segments and expanded approaches that enable the articulation of public policies and professional actions, seeking to promote health, child protection and full child development[2,4,14].

In children's health, care provided by health services should consider the various actors who play an essential role in child health protection, meaning parents, family, community and other caregivers who attend this clientele, including professionals of diverse areas[20]. However, as the mothers of this research point out, there are still gaps in assistance that limit the effectiveness of integrated actions in healthcare and the integral protection of children[20-21].

Prenatal care, which would be the first stage of comprehensive care for the child, proved to be fragile in the case of pregnancy of these adolescents, as it did not always occur adequately. Undoubtedly, quality prenatal care seeks health promotion and the prevention of risks related to pregnancy and the neonatal period, and assists in reducing maternal and neonatal morbidity and mortality[22]. Within the scope of prenatal care to pregnant adolescents, we need to pay attention to the peculiarities of these patients; that is to understand the differences of values and culture, favoring the establishment of dialogue and the autonomy of the subjects in the progressive organization of care[23].

Pregnancy and motherhood in adolescence are presented as a continuous learning process, and so that the teenager can face situations and participate more actively in the decision-making ahead of motherhood, she must be prepared and empowered, therefore the presence of a network of support is essential[9,24-25]. Coupled with this, it is important that health care allows for welcoming, bonding and that the responsibility of those who care is careful in recognizing rights, limitations and possibilities for everyone involved[6,13,15].

Some issues identified in the interviews show the concerns of teenage mothers envisioning the potential in professional actions to act in protecting the health of the child, based on a sensitive eye and committed practice in order to identify needs and vulnerabilities, with access to the necessary contacts and techniques, as well how to establish dialogue channels.

In this study, there was no mention of child health advocacy situations during childbirth, which may be due to it being a punctual event, and at the time of the interview it was already a relatively distant experience for the mothers, but this is also a crucial moment that needs several actions in ensuring the rights of the child and mother to healthcare.

In the context of defending children's rights to healthcare, monitoring their growth and development is fundamental, and child care should be understood as a moment of individualized care. This means evaluating the child, and extending this to the mother and surrounding family, which entails identifying vulnerabilities and promoting access to the necessary means[26]. Still, child care is a time that enables the monitoring of the mother-child relationship, health education, exchange of experiences and the formation of a partnership with a protective mother to child care that promotes the health and quality of life of the child[26-27]. It is noteworthy that when the child is in daycare, there are difficulties in attending childcare consultations. Therefore, the SF team should consider alternatives for the provision, considering the needs of these clients and the importance of ensuring the right to be absent from work to take the child to consultations, and flexibility in child care to get another time for routine appointments.

Essential elements for child care and advocacy encompass attention, sensitivity and communication skills by the health professionals, widening the social role of the subjects[26]. However, in some settings of adolescent mothers, the guidelines appear to be rules without openness to possible questions of conduct, without opportunities to answer questions about the health of their children, which creates uncertainty and concern. Still, these highlighted aspects suggest little articulation by the municipal health system, stressing both the need for strengthening the network of care to children and the need for continuing education of health professionals seeking to expand care and the relevance of forming partnerships with mothers and families, so that they can effectively contribute to the protection and guarantee of children's right to health.

Therefore, it is necessary that the health services are guided by integrity in attention, a central element to the consolidation of a health model that incorporates the universality and equity in practice, envisioning a guarantee to the right to health[19,28]. However, the results show that there

is still fragmentation in care services and professional relationships that expose the child to vulnerabilities because their needs are no longer met in full[20], and mothers feel abandoned by professionals and services. In light of these issues, and in order to achieve full attention and exercise the right to health, the practices need strengthening through the construction of accountability plans among the different social actors involved in child care[15,26].

The attitudes of health professionals in defense of child health should include a multiplicity of factors, with a breadth of understanding the health-illness process, making it imperative that to play the role of advocate for the health of those attending, the health professional, be it nurse, doctor or other, develops a communication process to create partnerships with all segments that may be necessary to guarantee the right to health[5,14]. However, in this study it was noted that partnerships with other mechanisms and social sectors were shown to be weak or non-existent.

The mediating role of child care exercised by nurses can be seen with great potential for defending the right to health[11]. So the nurse, through forming alliances, can also strengthen the citizenship of people[11], and contribute to building skills and resources through the development and shared implementation of an action plan that fosters well-being[15]. In this sense, it highlights the work of nurses in the FHS with possibilities for full and longitudinal monitoring of adolescents and children, which contributes to the enactment of defense practices and health promotion of these segments.

Adolescent mother empowerment is also presented as a defense of children's health. The perception of mothers together with their children as subjects who hold rights can help them to develop their potential and role, as well as in the construction of citizenship, helping reduce the distance between those exposed by laws and the concrete reality of life[7,12].

The survival of children is linked, among other relevant aspects, to the presence and involvement of another; they are dependent on the proximity of the care by the people performing protection functions and supply food, comfort and safety[3]. Another important aspect to highlight is that public policies need to influence the environment around the child and the community, health professionals and other areas and managers[3]. A positive environment includes key personnel with good interaction with the child and offers constructive opportunities for children to grow, learn and develop[3].

The listed aspects aim to maintain favorable conditions for development in early childhood and in later stages, ensuring that the early years are preserved and their rights certified[3]. Thus, an expanded role of health professionals involves potential subjects in the process of defending rights in childhood and adolescence, in pursuit of health promotion and protection.

CONCLUSION

In this study it was possible make a few observations on the right to child health care in the statements expressed by adolescent mothers. The right to children's health has taken on different meanings; however, the forms to guarantee them were linked to individual behavior in detriment to broader actions that consider health as a social product, connected to the guarantee of other fundamental rights. It has been determined that gaps in child care result in situations of vulnerability and depriving the exercise of the right to health. In addition, the attitudes of health professionals to the defense of children's health from the views of the studied mothers had limited contribution to building partnership networks and responsibility for children's health.

It should be noted that the need of defense principles for children's rights guide practices, effectively contributing to the promotion of health and to ensuring children's rights, and the importance of maternal empowerment for the defense of children's health.

Importantly, the results of this study relate to the context experienced by adolescent mothers who expressed some aspects, and therefore a thematic approach with comparisons to other maternal experiences can provide further input for the construction of practices focused on the defense and guarantee of children's health.

RESUMO

Objetivo: Analisar os cuidados à saúde da criança e a defesa de seus direitos na perspectiva de mães adolescentes. **Método**: Estudo exploratório com análise qualitativa temática dos dados, fundamentado em aspectos conceituais do cuidado e do direito à saúde, a partir de entrevistas semiestruturadas com 20 mães adolescentes adscritas por equipes de Saúde da Família. **Resultados**: Os relatos maternos apontam que o cuidado à saúde da criança requer responsabilidade e proteção, com práticas de saúde que promovam a defesa da criança. São também ressaltadas lacunas assistenciais que impedem a plena garantia do direito à saúde da criança. **Conclusão**: O direito à saúde assumiu diferentes significados e as formas de garanti-lo estiveram vinculadas a condutas individuais em detrimento de ações em rede que consideram a saúde como um produto social, interligada com a garantia de outros direitos fundamentais.

DESCRITORES

Criança; Adolescente; Direito à Saúde; Enfermagem Pediátrica.

RESUMEN

Objetivo: Analizar los cuidados sanitarios del niño y la defensa de sus derechos bajo la perspectiva de madres adolescentes. **Método:** Estudio exploratorio con análisis cualitativo temático de los datos, fundado en aspectos conceptuales del cuidado y el derecho a la salud, mediante entrevistas semiestructuradas a 20 madres adolescentes adscritas por equipos de Salud de la Familia. **Resultados:** Los relatos maternos señalan que el cuidado a la salud del niño requiere responsabilidad y protección, con prácticas sanitarias que promocionen la defensa del niño. Se subrayan también los hiatos asistenciales que impiden la plena garantía del derecho a la salud del niño. **Conclusión:**

El derecho a la salud asumió distintos significados y las formas de asegurarlo estuvieron vinculadas a conductas individuales en detrimento de acciones en red que consideran la salud como un producto social, interconectada con la garantía de otros derechos fundamentales.

DESCRIPTORES
Niño; Adolescente; Derecho a la Salud; Enfermería Pediátrica.

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