Chapter 97

Evaluation Of The Follow-Up Of Children Of Childcare Age During The Covid-19 Pandemic In Primary Care

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ABSTRACT
Introduction: Children were one of the most affected audiences during the pandemic by COVID-19, bringing several concerns of how such context may affect child development in the long and short term. Objective: To identify whether the pandemic by COVID-19 affected the follow-up of the comprehensive health assessment of children of childcare age and the overall development of this public in the context of Primary Health Care. Methodology: This research is characterized as a quantitative descriptive study. A population of 666 records of users from 0 to 24 months of age was analyzed. Results and discussion: Among the total sample, 473 children were present at the consultations and 193 were absent. Final considerations: It is necessary to carry out permanent education actions with health professionals, so that the teams can develop strategies for health promotion and effectiveness of continued care for the child and the family. It suggests that further studies be conducted to evaluate the impact of the pandemic by COVID-19 on child development.

Keywords: Child Healty, Child Development, Comprehensive Health Care, COVID-19, *Primary Health Care*.

1 INTRODUCTION

The COVID-19 pandemic has had a great impact on the lives of children and adolescents, bringing about changes in the lives of this public, with direct factors, which may be infection by the virus itself, and indirect factors, such as the consequences of social isolation. [1]

With this, the health services have had to adapt their routine and modify their operation, especially in Primary Health Care (PHC), where most municipalities have directed care with a focus on symptomatic cases by the new Coronavirus.[2]

Children were one of the most affected groups during this period, raising several concerns about how such a context can affect children's development in the long and short term.[2] For the most part, children's overall development occurs during early childhood, which can be compromised by social distancing and other effects caused by the pandemic.[2]

It is estimated that the adaptations of services can hinder the realization of child health care practices.[4] Some activities essential to this routine, such as immunizations, medical appointments, nursing care, and home visits, were jeopardized, reduced, or not performed at all by the health teams. [4]

PHC has the fundamental role of monitoring the mother and the newborn in all phases, from prenatal care that directly impacts the health of the pregnant woman and the development of the fetus, until after hospital discharge, even during the first week of the child's life, in which care should be provided by the primary care team, preferably during home visits, especially for guidance and care of the newborn. [4]

According to the World Health Organization, failure to immunize children routinely can increase the likelihood of outbreaks of vaccine-preventable diseases, and the most vulnerable to these diseases are children of breastfeeding age.[5]

The research aims to identify whether the pandemic by COVID-19 affected the follow-up of the comprehensive health assessment of children of childcare age and the overall development of this public in the context of Primary Health Care, evaluating from the gestational period and childbirth, in addition to highlighting the importance of conducting consultations, especially in the recommended age groups for better promotion, health maintenance and welfare of the child and the family.

2 METHODOLOGY

This research is characterized as a quantitative descriptive study**.** A population of 666 medical records of users aged 0 to 24 months was analyzed. The sample included users living in the Guajuviras neighborhood of the municipality of Canoas, Rio Grande do Sul, with a specific Family Health Clinic (FHC) as reference unit, who had at least one childcare consultation scheduled with the nurses and/or the medical team, with the child present or absent at the consultation, during the period from March 2020 to March 2021.

As a delimitation of the study, children older than 24 months; who had no childcare consultation scheduled with a doctor or nurse; who appeared repeatedly in the system; and; who do not have the FHC in question as a reference unit were not included in the sample.

In the first stage, to perform the data analysis, the initial sample was divided into two categories. The first category, entitled **Present at Childcare**, included the users who attended the scheduled appointments, and the second, characterized as **Absent at the Consultations**, included the children who did not attend any childcare during the period.

In the second stage, the analysis of the categories was performed. In the category **Present in Childcare,** the evolutions of the care provided by the nursing and medical staff in the users' medical records were evaluated, in which they observed whether there were factors that could show whether the pandemic by COVID-19 affected the follow-up of the comprehensive health evaluation of the child. The data analysis script A was used to evaluate this category.

As for the Absence at Consultations Category, the reason for the absenteeism of the user and the family at the consultation was verified, and the conduct of the Family Health Strategy team regarding the child's non-attendance was analyzed. In this category, the script for data analysis B was used.

Respecting resolution No. 466/2012 of the National Health Council, of the Ministry of Health, which legislates on the ethical aspects of research on human beings, the Term of Commitment to Use Data (TCUD) was granted, committing to secrecy in the data collected, maintaining privacy and confidentiality to the participants served.

The project was presented and approved by NUMESC (Núcleo Municipal de Educação em Saúde Coletiva) of the municipality of Canoas and after approved by the Research Ethics Committee by CAAE number 56821822.9.0000.5349 of the Universidade Luterana do Brasil.

3 RESULTS AND DISCUSSION

3.1 PREVIOUS TO PANDEMIC BY COVID-19

In the year before the pandemic period per COVID-19, corresponding to 03/01/2019 to 02/28/2020, the FHC in question carried out a total of 960 consultations with children from 0 to 2 years of age in childcare appointments with the nursing and medical teams. In addition, there were only 204 absences, for a total of 1,164 appointments scheduled during the period.

Evidencing thus, in the previous interval 498 more appointments were made if compared to the research period (during the pandemic by COVID-19), being a reduction of 42.7% between the corresponding periods. However, if we observe the quantity of users who were absent, during the sample period there were 28.9% absences, and in the previous year there was only 17.5% abstention. Thus concluding that in the previous year a greater number of services were available and with a lower rate of absences.

3.2 CATEGORY: GIFTS IN CHILDCARE

Among the sample of 666 users' medical records, 473 were present in the consultations, and this was the initial sample of category A. After analysis of the exclusion criteria, we excluded the medical records of users who were scheduled with other professional categories (55), those who appear repeatedly (97), those who attended the consultation for evaluation of signs and symptoms presented not being performed a comprehensive evaluation of the child's health (31), those who have links in another health service (30) and those who were excluded for not containing any evolution in medical records (23). Totaling the final sample with 237 users who attended the consultations.

3.2.1 Gestational And Childbirth Care

Regarding prenatal data, there are only 19 records of the number of consultations performed, and the largest were with six consultations (6), followed by ten (3), seven (3), nine (2), two (2), twelve (1), five consultations (1) and not having performed prenatal care (1). Regarding maternal age, there are few records (5), being the age groups 16, 25, 26, 32 and 37 years old.

The Ministry of Health recommends at least six prenatal visits during the entire gestation, alternated between the doctor and the nurse, with one visit every month until the 28th week, one visit every other week until the 36th week, and weekly until delivery.[5]

To ensure that the mother and baby have a healthy prenatal and childbirth, it is necessary that the first maternal consultation is performed until the 12th week and that, by the end of pregnancy, there are a minimum of six consultations.[5,6] The MS recommends that the first consultation should be held at the beginning of the gestational period, so that pregnant women can be given guidance on healthy prenatal care, facilitating adherence to consultations and the recommendations provided.[5,6]

An adequate prenatal care is extremely important for both mother and baby, since the child's development starts from the moment of conception. Therefore, the care taken during pregnancy is crucial for the child's growth.[7] The lack of prenatal care, or if done inadequately, may hinder the early diagnosis of changes in pregnancy, increasing the risk of maternal-infant morbidity and mortality.[8]

Still linked to the maternal data in the research, the survey on maternal education is only recorded in the medical records of mothers of Haitian origin (3), which, because they are of another nationality and schooling, generated difficulty in communication between professional and user, resulting in 234 records without this data.

It is important to note that maternal education is associated with the health literacy of this population.[9] Low schooling and other language (immigrants) are communication barriers found, since they reflect on the individual's ability to receive and understand the health orientations provided.[9,10]

We can observe, according to Chart 1, that the records of maternal data, entered into the children's charts during the childcare consultations, were mostly not made correctly and completely.

Table 1: Profile of puerperal women in the sample who had prenatal consultations.

Variables	n= 237 (100%)
Maternal Age:	
Unregistered	232 (97,8%)
From 19 to 39 years old	4 (1,6%)
Under 19 years old	1 (0,4%)
Number of prenatal visits:	
Unregistered	218 (92%)
No	1 (0,4%)
Two	2 (0,8%)
Five	1 (0,4%)
Six	6 (2,5%)
Seven	3 (1,3%)

Nine	2 (0,8%)
Ten	3 (1,3%)
Twelve	1 (0,4%)
Education:	
Unregistered	234 (98,7%)
Other education/nationality	3 (1,3%)

Source: own authorship. Elaborated from survey data (2020-2021).

The evaluation of intercurrences and risks that occurred during the prenatal and postnatal periods resulted in 163 (68.7%) users' charts with no changes, 37 (15.6%) with no record of such data in the chart, and 37 (15.6%) with a record of changes. Among the prenatal alterations, there are gestational diabetes (3), gestational hypothyroidism (1), pre-eclampsia (1) and cesarean section performed after another maternal cesarean section less than two years before (1).

As for the records of complications related to childbirth, it was observed that there are records of premature children (3), clavicle fracture (2), ingestion of amniotic fluid (2), leg dislocation (1), meconium ingestion (1), chorioamnionitis (1) and mother who used APS (psychoactive substances) at the time of delivery (1). The professionals also considered the use of forceps (2), hospitalization due to low weight (1), circular cord (1) and failure of induction resulting in cesarean delivery (1) as intercurrences.

During pregnancy, it is common for physiological changes to occur, considered as a variation of the usual pregnancy process, which may imply risks to the pregnant woman and the fetus. There are also individual characteristics of women that imply in a higher probability of a negative evolution to pregnancy, in which they are indicated as high-risk pregnant women.[11] However, it is evident that many of the complications could be diagnosed early and avoided with preventive measures and health promotion from an adequate prenatal consultation.[12] Many times, the pregnancy outcome, taking into account the complications, influences the type of delivery, the puerperium, and the child's health. In many cases, when diagnosed late, gestational and/or obstetric complications can cause unfavorable conditions for the pregnant woman and the fetus.[13]

The risk situations involving the gestational period and the child were: exposure to congenital syphilis - SC - (7), vertical exposure to HIV - Human Immunodeficiency Virus - (5) with two with false positive result after birth, and a joint exposure to syphilis and HIV (3). Users with exposure to syphilis and/or HIV were divided into the categories of those who performed the follow-up with the specialized service (5), those who did not (2), and those who have no record of follow-up or referral (8).

In the year 2020, Brazil had a total of 22,065 cases of congenital syphilis, having a decrease of 9.4% of cases if compared to the previous year.[14] CS is a public health problem, considered one of the leading causes of neonatal mortality in several countries. CS occurs when the *treponema pallidum* virus is transmitted from mother to baby, via placenta, during pregnancy, which can be avoided, and with the

possibility of cure, if the mother and her sexual partner are correctly treated. This exposure can bring several complications to the child, such as prematurity, neurological sequels, deafness, blindness, among others.[15] Fetal death, also considered a complication of CS, may reach about 11% of cases. [14]

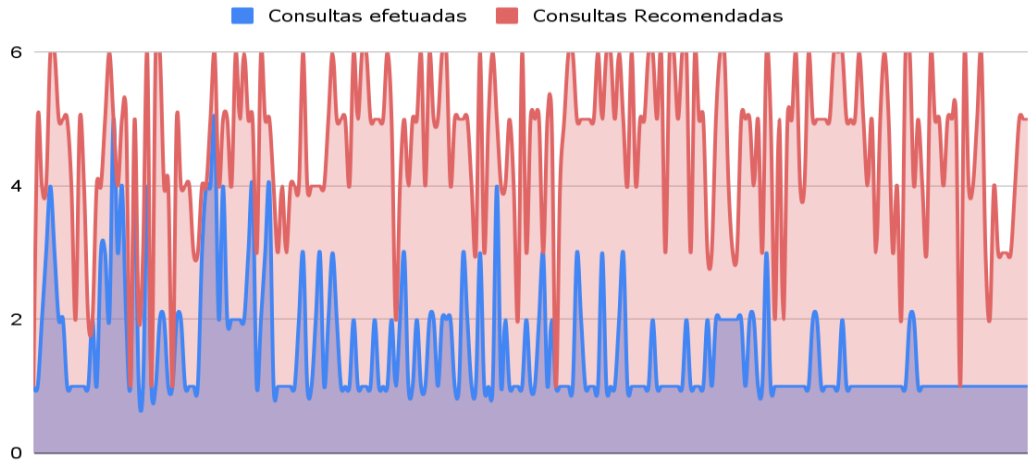
The HIV rates had an increase in the observed rate of live births of 28.6% when comparing the years 2006 and 2015. This growth, consequently, brings an increase in the risk of vertical transmission, which is the main means of HIV infection in children under 13 years of age. Most cases of mother-to-child transmission of HIV have 65% risk of transmission during labor and delivery, besides these, HIV can be transmitted via intrauterine, intrapartum and postpartum through breastfeeding. However, with preventive and prophylactic measures, through quality prenatal care and educational activities to the population, transmission rates can reach zero.[16] Because of this, it is extremely important that the puerperal woman and the child follow up with the health services.

3.2.2 Integral Child Health Care

Regarding the age of the first childcare consultation, there was a predominance of babies 30 days old (51), followed by 1 to 7 days old (6), 8 to 15 days old (55), 16 to 29 days old (56), 2 and 3 months (28), 4 and 5 months (8), 6 and 7 months (7), 10 and 11 months (5), 12 months (8), 15 months (2), 18 months (5), and 24 months (6).

Regarding the number of consultations, according to the age group of children, as recommended, one consultation (6), two consultations (10), three (25), four (51), five consultations (92), and six consultations (53) should be performed. However, during the sample period, one consultation (151), two consultations (55), three consultations (19), four consultations (10), and five consultations (2) were performed. It is important to emphasize that only in 10 cases the number of consultations was compatible with the ideal number, users who had one less consultation (26) than expected, two less (43), three (46), four (72), and five consultations less (29) than recommended. The distribution of consultations performed can be seen in Figure 1.

Figure 1: Distribution of the number of consultations performed x number of recommended consultations.



Source: own authorship. Elaborated from survey data (2020-2021).

According to the Ministry of Health, seven childcare appointments are recommended during the child's first year of life, being one 7 days after birth, in the 1st month, 2nd month, 4th month, 6th month, 9th month, and 12th month. Thereafter, the child should have clinical consultations at 18 and 24 months, and annually after 36 months.[17] The childcare consultations are carried out by a multiprofessional team, mainly doctors, nurses, and dentists, in addition to home visits by the CHAs together with higher education professionals, working to promote the child's health and the whole family context.[18]

In a study conducted in 2015, it showed that the first consultation for evaluation of the child, if performed early until the seventh day of life, reduces the rates of subsequent hospital admissions. The ages of the following consultations are associated, mainly, with the periods of immunizations and other care to promote children's health.[19]

3.2.3 Child Nutrition And Supplementation

The analysis of the data on infant feeding during the first six months of life showed that 119 users maintained exclusive breastfeeding, but 64 users did not perform exclusive breastfeeding and 18 did not breastfeed at any time, in addition to these, 36 did not have infant feeding addressed in consultation.

The failure to consult the baby in the first weeks of life, along with the lack of family guidance on the importance and encouragement of breastfeeding, contributes to early weaning, which can affect the child's health and development.[20] A survey conducted in 2020 found that among children who had 8 or more childcare consultations, there was a higher prevalence of exclusive breastfeeding, without the introduction of formulas or other milks.[21]

Those who did not perform exclusive breastfeeding were divided among those who offered the use of formula (40), those who started feeding before six months (11), those who offered only industrialized milk (9), and those who offered tea from birth along with breast milk (1).

For those who did not perform exclusive breastfeeding, the justifications were: by indication of the hospital to complement breast milk (23), did not produce breast milk (10), had "weak" breast milk (6), HIV-

positive mother or under investigation for HIV (8), and difficulty in breastfeeding (4). There are also records without any justification for not maintaining exclusive breastfeeding (31). As for those who offered the industrialized milk and not the use of formula as recommended, only 02 reported that they could not afford the formula, the others were not recorded.

Many times, the low production of breast milk may be associated with physical and psychological factors, which can be solved with professional guidance and help.[22] However, when it is not possible to perform exclusive breastfeeding, the use of formulas should be introduced, which is the most indicated to not interfere in the child's development, even if they do not have all the benefits of breast milk, dairy formulas offer the nutrients that the child needs in each phase. Offering formula can increase the risk of developing allergies and episodes of diarrhea.[23]

In the category of food introduction, there are records of the age of introduction for only 33 children, who started at eight months (1), seven months (2), six months (18), five months (8), four months (2), and three months (1). Moreover, there are users who were not approached with this information during the consultation (204). Table 2 shows the quantitative evaluation of the dietary data of the children included in the sample.

Table 2: Quantitative assessment of the diet of the children in the sample.

Variables	**n= 100%**
Exclusive breastfeeding:	**n= 237 (100%)**
Yes	119 (50,2%)
No	64 (27,0%)
Not breastfed	18 (7,5%)
Unregistered	36 (15,1%)
Use of formulas:	**n= 82 (100%)**
Yes	40 (48,7%)
Processed milk	9 (10,9%)
Food/tea offerings	12 (14,6%)
Unregistered	21 (25,6%)
Reason for using formula:	**n= 82 (100%)**
Hospital Indication	23 (28,0%)
Difficulty in breastfeeding	4 (4,8%)
"Weak Milk"	6 (7,3%)
Did not produce milk	10 (12,1%)
HIV-positive mother/under investigation	8 (9,75%)

Unregistered	31 (37,8%)
Age of food introduction:	**n=237(100%)**
Less than 06 months	12 (5,0%)
Over 06 months	20 (8,4%)
Not addressed in consultation	204 (86,0%)

Source: own authorship. Elaborated from survey data (2020-2021).

The MH, together with the World Health Organization (WHO), recommends that children be exclusively breastfed until they are 6 months old and then complementarily breastfed until they are 2 years of age or older.[24] Early introduction of complementary foods (before the age of 6 months) can contribute to increased cases of diarrheal episodes, lower absorption of important nutrients from breast milk, increased risk of childhood obesity, increased risk of food and respiratory allergies, and increased financial costs.[24,25]

According to the National Study of Infant Food and Nutrition (ENANI), a survey was conducted in 2019, the period before the pandemic, which showed that 96.2% of children in Brazil received breastfeeding at some point and 45.8% exclusive breastfeeding under 6 months, being far from the goals set by the WHO in 2030.[26]

The evaluation of the item of use of vitamins/supplementation for the child, 194 users did not have the use addressed in childcare consultation, 23 were prescribed supplementation and 20 did not use it. Among the prescriptions, the most recommended were: adtil with ferrous sulfate (16), adtil only (4), and vitamin D with ferrous sulfate (3).

Aiming to prevent micronutrient deficiency in the infant population, vitamins A, D, K, iron, and zinc are the main source of recommended supplementation in childhood, starting at 6 months of age, aiming at disease prevention and healthy development in this population.[27] It is up to health professionals to pay attention to this care.

3.2.4 Home Visits By Community Health Agents

In the analysis of the number of home visits by the professional Community Health Agent, 234 users did not receive any home visit, there are only records of users who received one (1), three (1), and four (1) home visits, however, in none of the medical records of those who did, is there any justification or evolution of what was done during the home visit.

The first care must be provided in the first seven days after birth to the mother-baby binomial at home by the Community Agent and the health team, while subsequent visits must be made according to need and risk factors.[4] Home care brings several benefits to the health of the child and the family, such as improvement in the cognitive development of specific groups, such as premature and low-weight newborns,

reduction in rates of violence and neglect of children, greater adherence to breastfeeding practice, management and identification of postpartum depression, among others.[4]

A study conducted in 2018 concluded that CHWs had difficulties in accessing families, with "closed" houses being a recurring problem and one of the biggest access barriers experienced. Even though the home-based activities of CHWs were impacted by the pandemic period, these obstacles were already identified previously.[28]

3.2.5 Neonatal Screening And Reflexes

The data pertinent to neonatal screening have 160 (67.5%) records in medical records of babies who have undergone all tests with no changes, and 27 (11.3%) have no record of screening. The remaining records were divided by each of the tests. The description of the ear test is delimited between those who did not perform (28) and with altered results (6), as for the tongue test, they are characterized as not performed (6), without record (2) and altered (1). Another evaluation is the little heart test, which was not performed (2) and not recorded (2). The Ortolani maneuver, there are only alterations (2). There is also the record of alteration in more than one screening, being in the test of the little heart and tongue (1).

Regarding the heel prick, 205 (86.4%) performed it, 28 (11.8%) have no record of the performance, followed by users did not perform it (2) and users performed it after 10 days of life (2). Among those who collected the heel prick, 117 (57.0%) users did not return to the consultation with the doctor or nurse for analysis of the test, not knowing if there was change in the evaluation, the others had no change in the result (88).

The recommendation is that the screenings occur in the first hours of life, with the exception of the heel prick, which should be done between the 3rd and 5th day of life of the child. Newborn screening allows for the diagnosis, treatment, and follow-up of disorders that may be identified through hearing, eye, heart, and blood screening. Early detection and treatment can increase the quality of life of the child, and it is essential that it is performed at the correct age group.[29]

Health professionals play a key role in providing guidance on testing since the prenatal period, in addition to developing strategies so that the screenings occur in the recommended age group, since the lack of evaluation can impact the child's physical and mental development, due to the fact that some diseases, which are asymptomatic, may not be detected early.[30]

Another item evaluated was the neonatal reflexes; however, in this item, there were few variations in the analysis, with only those who performed and had no alterations (215) and those who have no record in the medical chart (32), i.e., no child had alterations noted in the reflexes.

The primitive reflexes of the child must have their initial evaluation in the neonatal period, and may continue until 6 months of age, since both the absence of the reflex and its persistence must be evaluated. The execution of neonatal tests allows for the evaluation of the central nervous system, the identification of changes, and assists in early detection and treatment.[30]

3.2.6 Adherence To The Vaccination Calendar

Regarding the vaccination of these children, 173 (72%) were able to keep their vaccines up to date during the period, 34 (14.3%) had delayed vaccination, and in 30 (12.6%) childcare consultations the vaccines were not addressed. Among the vaccine delays, the ones with delayed vaccinations were BCG (4), delayed after the vaccines at two months of age (7), four months (2), five months (6), and the first vaccination was performed only after six months of age (1). Among the non-performance, there were children who did not perform BCG (14) and influenza (1).

As data from the Institute for Health Metrics and Evaluation indicated that due to the third wave of the pandemic COVID-19, vaccinations of children dropped from 84% in 2019 to less than 74% in 2020.[31]

Not vaccinating brings as a major risk the low population immunity, resulting in localized outbreaks of groups or specific populations,[32] since vaccines are the major vehicle for prevention, control and elimination of diseases.[33]

A study conducted in 2020 found that non-vaccination is related to low maternal education and difficulty in accessing health services for vaccination.[33] In the municipality where the research was conducted, the BCG vaccine, if not performed in the hospital where the child was born, is only applied in one health unit in the entire municipality, which may be a cause of low adherence.

It is up to the ESF team, especially the nurse, to track the children with vaccine delay and develop strategies within the community to increase the vaccination rates of that population, to reach the state indicators and help prevent new outbreaks of communicable diseases.

3.2.7 Global assessment of Child Development

Among the global development evaluation of the child, only 04 (1.68%) showed a variation in the evaluation, and the other 233 (98.3%) had no change considered by professionals. Among the four altered evaluations, the professionals considered suspicion of an ASD (1), suspicion of attention deficit hyperactivity disorder - ADHD (1), cognitive delay (1), and neurological alteration (1). Among these children, only one with suspected ASD was referred to the specialized service for evaluation and follow-up; the others are awaiting evaluation of signs and symptoms by the medical specialist to confirm the possible diagnosis.

It is important to consider that in this category were pointed out alterations that health professionals, at the time of the consultation, evaluated as relevant in the child's development, which need to be referred to a specialist or of a regular follow-up by the medical team. Other factors were not evaluated.

In the municipality where the research took place, such changes can be identified in primary care consultations and then referred to a specialist in secondary care. The early identification of such signs and symptoms is essential for the diagnosis, treatment, and follow-up to be started as soon as possible.

3.3 CATEGORY: ABSENCE IN CONSULTATIONS

In category B, among the 193 users of the initial sample, we excluded those who appeared repeatedly (104), who were not linked to the health unit in question (12), for being in other professionals' schedules (4), for not having any information in medical records (4), for blocking the agenda (4) and for consulting with clinical complaints without a comprehensive evaluation of the child's health (4). Resulting in a total sample of 61 users who did not attend any service during the research period.

Regarding the absent children, 42 missed one appointment, followed by absence in two appointments (12), three appointments (5), four (1), and five appointments (1), thus concluding that the 61 users generated a total of 90 absences during the period. Among them, most were absent from the appointments without justification (52), however, there are users who canceled their appointments in advance (6) and those who went to the unit for the appointment but did not wait for the service (3). Among the cancellations prior to the appointment only 3 users gave a justification, there are records of the user who claimed that the exams were not ready in time to show the professional (1) and that the child's guardians would be working on the day of the appointment (2). There are no records of justifications for cancellations or absences related to COVID-19.

As for the active search for missing children, the ESF team conducted only 5 searches, which were conducted through home visits by Community Health Agents (4), and by telephone contact (1). Only 02 users had the record of some conduct or guidance carried out after the active search, being a scheduled appointment (1), and a family was oriented to reschedule the appointment (1).

According to a study conducted in 2019, to increase adherence to childcare appointments, health professionals should develop strategies to increase children's attendance and make families aware of the risks of not following up on their child's health.[34]

Unfortunately, the low number of childcare appointments directly affects the child's health, growth, development, and the guarantee of the child's rights, compromising the promotion, prevention, and recovery of health of the child and the family nucleus.

4 FINAL CONSIDERATIONS

Regarding home visits, it can be observed that 98.7% of the sample did not receive any visit in the period in question, leaving the public unattended in this aspect. With the maternal data, it is observed a scarcity of records of professionals in the medical records of children included in the sample. The same occurs for the supplementation of children under 2 years old and food introduction, in which 81.8% and 86.0%, respectively, did not have this data recorded.

Another point observed is that the obstetric complications presented could have been avoided with quality prenatal care and with educational activities, but due to the lack of data recorded in the users' medical records, it is not known if the puerperal women had their prenatal care properly.

Among the item of neonatal screening and reflexes, it is important to emphasize that 57% of the children did not present the result of the heel prick to the health professional during the childcare visit.

Regarding vaccination, it can be observed that only 72% had vaccinations at the appropriate times, a rate lower than expected. Because of this, professionals should develop strategies to increase the number of vaccinated children and actively search for those who have delayed vaccination. In addition, the municipality can develop flows to facilitate the population's access to all vaccines, since this can be an obstacle to achieving higher rates of vaccination.

It is necessary that permanent educational actions are carried out with health professionals addressing the items that should be asked in childcare consultations, the comprehensive assessment of the child and the frequency of consultations, so that the ESF teams can develop strategies for health promotion and effectiveness of continued care for the child and the family. In addition, it is essential that it is seen with the professionals the importance of recording maternal and child data in the child's medical record, since the gestational and puerperal health reflects on the care generated to the child involved.

As a limitation of the study, there are no data available on the number of children registered in the territory of the FHC where data collection occurred, so it was not possible to verify the percentage of children in the territory who accessed the service during the research period.

It is suggested that further studies be produced that evaluate the performance of comprehensive health and development monitoring of children of childcare age by PHC health services during the period of the pandemic by COVID-19, since it is a subject of extreme importance to public health and will still have long-term repercussions.

5 AUTHOR CONTRIBUTIONS

Conception and design of the research; Methodology; Data collection; Data analysis and interpretation; Statistical analysis; Writing of the manuscript: Silveira, CR. Critical revision of the manuscript; Supervision; Validation: Camargo, MEB.

6 CONFLICT OF INTEREST

I declare that there is no relevant conflict of interest.

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