Research Article **RJPP 2017 1:12**

Research Journal of Pharmacology and Pharmacy (ISSN:2572-8377)

CHARACTERIZATION OF OCCUPATIONAL PROFILE: CHILDREN'S EDUCATION STRATEGIES IN THE FIELD OF HEALTH

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ABSTRACT

Draw an occupational profile of babies and children and describe the health education activities carried out by occupational therapist in a university context. Descriptive cross-sectional study, according to documentary survey. Information form of the children were examined during practical lessons of discipline Occupational Profile of Children and Adolescents, the Occupational Therapy course at the Federal University of Pernambuco, from February 2012 to January 2014. Caregivers brought demands on overall development of children. Thus, occupational therapy intervention is directed, within the health education perspective, in accepting these demands and advise on the performance of occupational roles corresponding to each age group in order to promote normal development and prevent delays and / or commitments future.

Keywords: Health Promotion, Human Development, Health Education, Occupational Therapy.

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How to cite this article:
OLIVEIRA, M.P.C.A, FERREIRA, A.P.A and RABELO, A.R.M et al.,. CHARACTERIZATION OF OCCUPATIONAL PROFILE: CHILDREN'S EDUCATION STRATEGIES IN THE FIELD OF HEALTH. Research Journal of Pharmacology and Pharmacy, 2017, 1:12

eSciencePublisher

eSciPub LLC, Houston, TX USA.
Website: http://escipub.com/

INTRODUCTION

Satisfactory growth and development, especially in the early years of life, establish a critical base for health and academic success of children, considering the specificities of that period of vulnerability[1].

Both are complex processes, because they follow a determined and organized sequence and receive influences from several factors, whether social, psychological, biological, environmental, emotional. Thus, in addition to the biological aspect, environmental stimulation by parents and by society contributes to the formation of a new life[2].

It is important to point out that within an environmental context the family links can become a risk factor, as there's a fragility of these links or can become a protector factor, when this family offers the suitable socioemocional support[3]. For this to be a vulnerable period, it is important that the family, health and education professionals have a special attention to this clientele, helping them deal with situactions and problems that might cause damage and harms to health[4].

Thus, the variety of factors involved, it is common in this phase to identify children who are not able to perform activities expected to their chronological age in one or more areas of development, thereby establishing a delay[1].

From the perspective of occupational therapy, children with delayed development often meet challenges in occupational performance, especially in the play, showing a decrease of exploratory behavior causing experience few experiences. Thus, in daily activities, there is a slowness in implementation of self-care activities; and school performance, there is a greater difficulty in learning process[1,5].

The occupational profile corresponds to a summary of the history of occupations that the subject plays and of experiences, including standards of living, interests, values and needs of that client in relation to the current situation6. In this study, it was intended to identify the profile of children in order to identify the demands, intervene early, and Guide according to the need to minimize the negative effects that the development may cause delay in the future life of the child and his family[2].

The primary health care is a form of attention, which is the main gateway of the health system, with the principles the completeness, the centrality in the family, the orientation to the community and fitness culture[7]. This mode of attention was introduced worldwide in terms of prevention and health promotion, directed to children and women, with strategies to monitoring of growth and development, breastfeeding, immunization and family planning[8].

Within this process, the orientation is essential to ensure the involvement of the client and the family in therapeutic interventions. To this end, it is necessary to pay special attention to the quality of the information provided, considering the language used as the caregiver's education level, the demand of the child and the family, their previous experiences[9].

This guidance is made in the context of health education, because this is a feature through which the knowledge produced in the field of health, brokered by health professionals, reaches the everyday life of the people, in order to prevent disease and promote health[10].

Understanding that health education is a broad and complex process, it is essential that this construct of knowledge is shared, critical analysis and discussed by the reality of the subject, making room for dialogue, allowing the criticality of the subject about his health condition[11,12,13]. Within this perspective, the occupational therapist helps the individual promotes your health critically, but always engaged in any occupation[14].

In this sense, the aim of this paper is to draw the occupational profile of babies and children and describe the actions of health education carried out by an occupational therapist in a University context.

METODS

This is a descriptive and retrospective study with cross section. The survey was conducted in the occupational therapy department at the Federal University of Pernambuco (UFPE/DTO) through the Occupational Profile Discipline of children and adolescents, which deals with children's normal youth development, and brings in his methodology reviews/comments of the occupational performance typical of children and adolescents, in order to trace the occupational profile of these, making a listening to the complaints and demands of parents/caregivers, clarifying your questions and guiding them about human development.

The dynamics of the discipline consisted of: initial contact with the families to explain the proposed discipline and questioning about the difficulties and potentialities of the child related to the performance of everyday activities; During the sessions, were collected information by means of an unstructured interview, conducted by an occupational therapist/teacher responsible for discipline, which contained data on the age, sex, degree of kinship caregiver, complaint/demand date of the evaluation, the main behavior of child/adolescent, observed aspects of the caregiver, vacant of an occupational therapist for the return of family caregivers on the guidelines and additional notes, and finally, these interviews were filed with the teacher responsible for discipline.

The children of this survey targets were according to the characteristics of the discipline: with age matched between newborn to 11 years; no sex restriction; and with typical development. Spontaneously, the children/adolescents were invited to participate in the note, which was performed in meeting only; identifying complaint/demand of the caregiver and/or child/adolescent. The fed back of the caregivers were collected immediately after the guidelines given in day. In this study, we analyzed the actions developed in the period of February 2012 to January 2014.
The data were analyzed in simple frequency and discussed according to what was found in the literature on the topic in question. The study was approved by the CEP/UFPE (CAAE number 23122713.1.0000.5208).

RESULTS

The sample consisted of 20 children between 4 months and 9 years, observed during the preset period.

Table 1 presents information related to age, gender and the relationship of children and adolescents surveyed. Age, 50 % were between 0 to 2 years of age (baby), 50 % from 2 to 11 years (children). When it comes to sex, predominated the feminine with 56 %, and most caregivers with 60 %, was composed of mother/father, followed by relatives (Sister, Uncle, Grandfather/

grandmother, press) with 36 %.

Table 1: identification of the biological and social profile of the subjects of the research. Recife/PE, 2014.

Characteristic	N = 20		N	%
*Age**	Baby	0 – 1 Incomplete	5	*20*
		1 – 2 Incomplete	5	*20*
	Child	2 - 6	7	28
		7 – 11	3	12
Sex	Female		12	60
	Male		8	*40*
Caregiver	Father/Mother		14	*70*
	Relatives		5	25
	Babysitter		1	5

* In accordance with the Statute of the child and adolescent (ECA), Law 8069 of 1990.

The frames 1, 2, 3 and 4 below show the age of the subject; complaints/demands of caregivers; the record of observations of children during the evaluation process and the orientation of the occupational therapist for caregivers based on the complaints and observations. These guidelines were based on a benchmark of health education already described previously.

The frame 1 referring to data from 0 to 1 year babies incomplete, indicates that the complaints of the caregivers relate to the Neuropsychomotor Development, demonstrating the interest of those in information and possible ways to stimulate the child in order to facilitate its development.

Subject/Age	Complaint/demand	Comments	Guidance Ter. Ocupac.
A 4 m	Difficulty in shower sitting/wants to be on his arm, with the adult always standing	*Baby:* good interaction with the environment/low frustration level/Resists the stay of prone and supine	Work the frustration with the child/does not pass the "blackmail"/stimulate the child to go to the floor
B 5 m	Doubts about the DNPM and the effects of overuse of the stroller.	*Baby:* Performs postural changes, but with little functionality of the upper limbs (MMSS)	Promote the use of more functional MMSS in play and the postural changes/stimulate the child to go to the floor
C 6m	Doubts about the DNPM/Just want to stand up/Conduct distinct from parents	*Baby:* Good DNPM/resistance in use upper limbs and holding the bottle/little tolerance at the end of the power supply.	Encourage the child to go to the floor, using rubberized mats/stimulate independence in feeding/Pass the guidelines for Dad.
D 7m	How to stimulate the DNPM/stays for a long time with the tongue out of the mouth.	*Baby:* Postural changes, crawls makes/Uses the lower limbs, making standing posture, even with assistance.	Allow the environmental exploitation/reduce the amount of toys offered at the same time, as well as the use of Tablet/encourage independence in feeding/oral muscle stimulating exercises.
E 11m	Resistant to walk, even with support.	*Baby:* Postural exchanges with difficulty (four foot support)/dependent on feeding/Uses the cry in front of no.	Allow the environmental exploitation/stimulate the postural changes and completion of the walk alone/to encourage independence in feeding.

The age group between 2 to 11 years are marked by demands on the child's personality and his/her DNPM (frame 3 and 4). In this phase the guidelines relate to a healthy routine for your child, always stimulating about access to toys and places suitable for their age group.

Frame 3: characterisation of the occupational profile of the children from 2 to 6 years. Recife/PE, 2014.

Subject/Age	Complaint/demand	Comments	Guidance Ter. Ocupac.
*A** 2a	How is the development of the child.	*Child:* Good DNPM/obey/even crying, sporadically, and stuck a pacifier and doily, managed to give an account of everything that has been requested.	Good DNPM, but we must organize the routine occupational child with parents free time.
B 2a 8m	How to deal with the temper of the child.	*Child:* Good DNPM/Difficulty in troubleshooting, using some familiar.	Establish clearer limits/Encourage independence in problem solving.
*C** 4a	Very polite, does activities for the little sister.	*Child:* Good DNPM/high concentration and good problem solving/difficulty speaking some letters.	Watch the language, in order to perform an evaluation with a speech therapist/Encourage a less protective posture in relation to the younger sister.
D 4a	Very active, has no daily routine and sleep too late.	*Child:* Good DNPM/didn't want to call it a joke, demonstrating excitement/Quite concentrated in the activities/creative/Difficulty in naming colors.	Organize routine/Provide some body/activity Stimulate learning of colors.
E 4a	Pasty in food textures rejects.	*Child:* Slow motor development (slight hypotonia)/Initially rejected Pasty stimuli, concern get dirty/Later, allowed himself to try and interacted with all textures/Shy, but had good interaction.	Explore more games with tactile stimuli/allow try other textures and becomes dirty it will reflect in the feed.
F 5a	How is the development of the child/ If the child is very "accelerated".	*Child:* Good DNPM/high expectations with the exploitation of the environment.	Organize occupational routine/Offer suitable spaces for the child's age.
G 6a	Authoritarianism	*Child:* Difficulty in planning/motor Difficulty in assembling puzzle/initially very shy/After, quite aggressive when challenged verbally offended the therapist.	Adjust the use of games and toys with the age group/Check the existence of Bullying at school/Impose limits with clear rules and common to all the adults in the House.

Frame 4: Characterization of the occupational profile of the children from 7 to 11 years. Recife/PE, 2014

Subject/Age	Complaint/demand	Comments	Guidance Ter. Ocupac.
A 7a	Lack of attention/overuse of electronic games/paternal Boundaries	*Child:* Great difficulty in postural changes/Dispersed with little ability for problem solving/uses charades to communicate/Creative.	Rescue and diversify activities/Stimulate the language through the "make-believe"/Establish rules for use of electronic equipment.
B 8a	Has some "fears" related to the death.	*Child:* Good DNPM/aversion to some tactile stimuli/a lot of imagination, combined with information from the internet.	Restrict the use of the internet and news hyped/explain the issues pertaining to death, according to the different religious conceptions of the family.
C 9a	Clutter	*Criança:* Quite active in search of stimuli, but can concentrate on calmer activities/a lot of imagination and creativity.	Build a timeline to create an occupational/routine stimulate store the toys soon after finishing the game, establishing clearer rules.

DISCUSSION

The child's interaction with others and with the adult is one of the main elements for an appropriate stimulation in the family space and helps her develop her perception, drive and control its behavior, in addition to acquiring knowledge and skills[3].

Primary caregiver is the person responsible for the care and the child's diary, and that may be the mother, father, grandmother, or any other person who performs this role[15]. In this context, the caregiver has a fundamental role in the development of the child as it is responsible for fostering a stimulating environment[5].

Has that most often the health professional is the only source of information for family members[1]. So, in order to overcome the gap between the professional and the population, as a strategy of health education orientation that aims to promote health through a shared construction of knowledge, in a horizontal perspective of knowledge[13].

Therefore, in this study was used as a strategy for health education orientation, which prioritized the demands brought by caregivers as well as the context in which they were entered. It is noticed that a large part of the caregivers actively participated in the process of assessment/observation of the children along with the occupational therapist and reported complaints and specific demands of your child as well as the difficulties encountered in their daily lives.

When reviewing complaints/demands brought by caretakers of babies on the DNPM, various questions arise at this stage due to the rapid development in the age group of 0 to 2 years. At that stage the baby's physical development, cognitive, sensory, social and emotional enough to experience accelerated experience, because your Musculoskeletal and nervous system is constantly growing and this influences and is influenced by the activities and experiences of the child[16].

The child develops when it is in the State of maximum coherence with the physical environment, socio-economic and cultural, social, playing significant roles that change in the course of your life1. Therefore, the need for stimulation of

the baby to have more independence in activities of daily living (ADL), activities focused on the care of individual with his own body, because these experiences will assist the development and consequently the behavior of the child.

In this context, the occupational therapist is able to develop strategies, adaptations, guidelines for the ADL, because these activities that the individual develops throughout his life, are considered areas of occupancy of the field of occupational therapy practice[17]. In addition, the guidelines were based on respect for the other, in look and listen understanding, in an unprejudiced stance, and in a relationship of empathy and help to these caregivers, according to the assumptions of health education[11,13,18,19].

Considering the age of 2 to 11 years, children become more independent in the motor area and start the exploitation of the environment in more intense, absorbing everything offered to him. In addition, the personality of the child begins to be shaped, reflecting on the emergence of questions of what limits should be given in complaints/demands of caregivers[20].

During this period, it is important to note that all children may go through the phase of shyness, aggressiveness or constant irritability. This occurs due to transitions, new routines, which can lead to changes in behavior and development changes[20].

Thus, it is essential in addition to the guidance by the occupational therapist, which is able to teach knowledge and skills needed to increase the welfare of children9, the active participation of the actors involved[11,12,13], so that they reflect critically about these guidelines within the context of life. Among the guidelines given to carers in research, stands out for this age group the stimulation of caregivers to develop a routine for your child, and clear rules about what is allowed to do, without interfering negatively in their development.

Thus becomes important to creating a stimulating and rewarding environment for children, providing them with information through all senses[20].

Therefore, the occupational therapist within the perspective of health education, will help the children and caregivers organize to support routine and well-being to both stimulate the engagement in meaningful occupations, guide parents about their children's development as well as its relationship with them[9], establishing settlements, horizontal form, in order to contribute to the disruption of the authoritarian relations and enhancing the knowledge of caregivers[11,12,13].

In addition, from the perspective of Primary health, the occupational therapist acts in the area of health promotion and prevention of diseases with actions at all times, whether in individual or group calls, in home visits, intersectoral and community-wide, in order to promote quality of life to the individual and their family members[8].

So, it behooves every health worker develop health education activities, including occupational therapists, being necessary to consider the involvement of the population in the construction and reconstruction of knowledge, from your daily life, and enhancing the empowerment of the subject[11,13,18,19]. From the perspective of this study, these actions were geared to meet the concerns of parents about child development, identify risk factors and protection for the development, and

make the appropriate guidelines[21].

FINAL CONSIDERATIONS

Considering the various possibilities that hampers development delay in occupational roles of the child, it takes a larger customer demand listening children and their caregivers, in order to provide appropriate guidance and relevant to client/family and thus prevent these delays or intervene when are already present.

In this perspective, when that wire is made, one can see that in this age group the areas of occupation that caregivers bring concern are related to daily life activities, play and education. Thus, occupational therapist's role is to stimulate the children's occupational performance, maximum for satisfactory development.

Therefore, the educative actions in health are an important strategy to promote the health of children, as well as to empower these caregivers on stimulation of the development of the same, in addition to providing an exchange of knowledge between professionals and subject.

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