Original Article

Baby follow-up in primary care: interface with the third stage of the kangaroo method

Seguimento do bebê na atenção básica: interface com a terceira etapa do método canguru

Seguimiento del bebé en la atención básica: interface con la tercera etapa del método canguro

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Luana Cláudia dos Passos Aires[a]
Evanguelia Kotzias Atherino dos Santos[b]
Roberta Costa[b]
Márcia Borck[c]
Zaira Aparecida de Oliveira Custódio[c]

ABSTRACT

Objective: To know the perceptions of health professionals in primary care on the follow-up of preterm and/or low birth weight babies and their families, and the interface with the third stage of Kangaroo Care.

Method: Exploratory and descriptive research with a qualitative approach, carried out in Basic Health Units in the municipality of Joinville, Santa Catarina. The data were collected between September and October of 2014, through semi-structured interviews, with 31 health professionals. Data treatment was performed through content analysis technique, thematic modality.

Results: The following categories emerged: Segment organization in Primary Care; The enigmatic preterm and/or low weight baby and childcare in primary health care; The interfaces of the third stage of Kangaroo Care with Primary Care.

Conclusion: The use of Kangaroo Care in Primary Care is still shy, caring for preterm babies is fraught with uncertainty and still focused on the biomedical model.

Keywords: Child care. Primary Health Care Kangaroo care. Premature. Millennium Development Goals

RESUMO

Objetivo: Conhecer as percepções dos profissionais de saúde da Atenção Básica sobre o seguimento do bebê pré-termo e/ou de baixo peso e sua família e a interface com a terceira etapa do Método Canguru.

Método: Pesquisa exploratório-descritiva, com abordagem qualitativa, realizada nas Unidades Básicas de Saúde do município de Joinville, Santa Catarina. Os dados foram coletados no período de setembro a outubro de 2014 através de entrevistas semiestruturadas com 31 profissionais de saúde. Para o tratamento dos dados, utilizou-se a técnica de Análise de Conteúdo, modalidade temática.

Resultados: Emergiram as categorias: Organização do seguimento na Atenção Básica; O enigmático bebê pré-termo e/ou de baixo peso e sua puericultura na Atenção Básica; As interfaces da terceira etapa do Método Canguru com a Atenção Básica.

Conclusão: A participação da Atenção Básica no Método Canguru ainda é tímida, o cuidado prestado ao bebê pré-termo é permeado de insegurança e ainda focado no modelo biomédico.

Palavras-chave: Cuidado da criança. Atenção primária à saúde. Método canguru. Prematuro. Objetivos de Desenvolvimento do Milênio.

RESUMEN

Objetivo: conocer las percepciones de los profesionales de salud de atención de la Atención Primaria, sobre el seguimiento de los bebés pretérmino y/o de bajo peso al nacer y su familia, y la interfaz con la tercera etapa del Método Canguro.

Método: Estudio exploratorio, descriptivo, con abordaje cualitativo, realizado en Unidades Básicas de Salud en el municipio de Joinville, Santa Catarina. Los datos fueron recogidos entre septiembre a octubre, 2014, a través de entrevistas semiestructuradas con 31 profesionales de la salud. Para el tratamiento de los datos se utilizó la técnica de análisis de contenido, modalidad temática.

Resultados: Emergieron las siguientes categorías: La organización del seguimiento en la Atención Primaria; el enigmático bebé pretérmino y/o de bajo peso al nacer y su puericultura en la Atención Primaria; Las interfaces de la tercera etapa del Método Canguro con la Atención Básica.

Conclusión: La participación de la Atención Primaria en el Método Canguro aún es tímida, y el cuidado al bebé pretérmino está permeado de inseguridad y todavía está centrado en el modelo biomédico.

Palabras clave: Cuidado del niño. Atención primaria de salud. Método madre-canguro. Prematuro. Objetivos de Desarrollo del Milenio.

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[a] Maternidade Darcy Vargas (MDV), Unidade Neonatal. Joinville, Santa Catarina, Brasil.

[b] Universidade Federal de Santa Catarina (UFSC), Departamento de Enfermagem. Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.

[c] Hospital Universitário Professor Polydoro Ernani de São Thiago (HU/UFSC). Florianópolis, Santa Catarina, Brasil.

INTRODUCTION

Preterm birth is a major public health problem worldwide. Annualy, 15 million preterm babies are born in the world, an approximate incidence of one in ten births[1]. Neonatal morbidity and mortality are responsible for the concern about this issue, since each year more than one million of these Newborns (RNs) die within days of birth around the world, being this the second cause of child mortality [1] .

In 1999, the "Humanized Care for Newborn Low Birth Weight (NAHRNBP) – Kangaroo Mother Care" [2] arrived in Brazil, proposing to humanize care for hospitalized newborns in order to meet the demands for developmental care of preterm and/or low birth weight babies, The *Kangaroo Mother Program (Programa Madre Canguru, in portuguese),* originally designed in Colombia in 1979, aimed to reduce the mortality rate, cross-infection and the costs of neonatal care. In Brazil, the method is formalized as a Public Health Policy, with its nomenclature adapted in the country to Kangaroo Methos (MC, or Método Canguru), because it is seen an action that not only reaches the binomial mother/son, but the entire family core. In Brazil, the method aims mainly to humanize and qualify neonatal care, promoting the overall development of the child and family ties [2].

The method, among several actions that integrate it, is recognized for its skin-to-skin contact, offered by the "Kangaroo Position". It is performed in three stages, the first in the Neonatal Intensive Care Unit (NICU) and in the Conventional Intermediate Neonatal Care Unit (UCINCo), the second in Intermediate Neonatal Kangaroo Care Unit (UCINCa), and the third after hospital discharge, at home[2].

The third stage of MC consists in monitoring the child after hospital discharge in the clinic and at home. MS proposes the participation of Primary Care (AB) in conjunction with the hospital at this stage, through actions performed by the Family Health Strategy (ESF) teams in Home Visits (VD)[2].

However, it is known that the coordination between the various health care levels is not yet significant, which results in hospitals being the predominant place where these babies are monitored [3]. Studies indicate the need to invest in AB for the care of preterm and / or low birth weight infants[3].

Considering the lack of literature reporting the participation of AB in the care of preterm and / or low birth weight infants, characterized by the meager amount of published studies on this thematic, as well as the need to identify its strengths and limitations in this context, the following guiding question emerged: What are the perceptions of professionals from the Primary Health Care teams about their participation in the follow-up to the egress preterm and/or low weight babies from the neonatal unit and their families, and the interface with the third stage of Kangaroo Care?

Thus, the study objective was established: To know the perceptions of health professionals in primary care on the follow-up of preterm and/or low birth weight babies and their families, and the interface with the third stage of Kangaroo Care.

METHOD

This is an exploratory and descriptive research with a qualitative approach, derived from the Master Thesis entitled "Perceptions of health primary care professionals on the follow-up of preterm and/or low birth weight babies and their families: interfaces with the third stage of the Kangaroo Mother Care", presented at the Graduate Studies Program in Nursing at the Federal University of Santa Catarina – PEN/UFSC [4].

The study was held in Basic Health Units (UBS) in the city of Joinville, located in the northern state of Santa Catarina (SC). The city has 57 UBS' distributed in nine health regionals. Since 2009, the municipality has been developing since the project entitled "Monitoring Strategy of the child in risk conditions – Precious Baby Program", aiming to reduce child mortality and comprehensively address former Neonatal Unit (UN) patients who are children at risk, ranging from 0-11 months and 29 days [5].

With regard to maternal and neonatal care on the tertiary level, the city studied has Maternity Darcy Vargas (MDV), linked to the State Health Department of Santa Catarina (SES/SC), that, in 2013, won the title of state reference for MC, as the main hospital related to the Precious Baby Program.

AB health team member professionals (doctors, nurses and nursing technicians) acting in AB for at least six months, effectively hired or contracted under other forms of law, and who had attended pre-term and/or low weight babies referenced by the Precious Baby Program, were included as participants in the study.

The exclusion criteria adopted were the following : professionals on leave or vacation from assistance, and that were removed from service in the past six months. The number of participants was defined by the data saturation. Data collection took place between September and October of 2014, through semi-structured interview. The schedule for the interviews was according to the choice of time and place made by the participant, while the call for participation in the study was made personally.

Of the 29 UBS' that had attended "Precious Babies" in the years 2013 and 2014, identified by the program coordinator, 15 UBS' were visited for the purpose of data collection, with the intention of encompassing most of the nine health regionals. Interviews were conducted in reserved environments, calm and with minimal external influences, being recorded and transcribed by the main researcher. In three interviews, participants refused to be recorded. In these cases, the data was registered soon after, to ensure the originality of the data. The interview durations ranged from 08 to 35 minutes.

Data were analyzed using the thematic category content analysis technique[6] followed by the pre-analysis steps, material exploration or coding and processing of the results – inference and interpretation. This proposal focuses primarily on the exploitation of opinions and social representations on the subject investigated[6]. In pre-analysis, after the transcription of the interviews, a brief reading of the analysis body was and the formulation of hypotheses was held. At the material exploration stage, the categorization of the data was performed from the exhaustive reading and saturation of that data in the statements. Finally, in the inference and interpretation phase, the information obtained was analyzed reflectively and critically in light of the theoretical framework, which in this study, were the Public Health Policies [6].

The study followed the standardization of research activities and interventions with humans, in accordance with Resolution 466/12 of the National Health Council [7], with the inclusion of the study participants only occurring after formal authorization through the signature of the Free and Informed Consent Form, before which they were informed of the nature of the study and able to clarify any doubts. Participants were granted the right to leave the study at any time and also were also granted anonymity through identifications formed by letters "E" for Nurses, "M" for Medical and "T" for Nursing Technicians. The research project was submitted to the Brazil platform and approved by the Ethics Committee of the SES/SC under substantiated opinion number 767.502 of August 27, 2014.

RESULTS AND DISCUSSION

The study gathered 31 AB professionals, with 14 nurses, nine physicians (six family health practitioners and three pediatricians) and eight nursing technicians. Most professionals were female, and the ages ranged between 27 and 60 years. 64.5% of participants were part of the ESF, and the amount of time working in AB ranged from eight months to 27 years, and the time since graduation from two to 36 years. Of the participants surveyed, 29% had other employment.

The analysis of the interviews revealed three categories:

Segment organization in Primary Health Care

In the studied reality, the opinions of health professionals diverged regarding the proposed query interval for to monitoring the child in AB proposed by the Ministry of Health (MS) . The main concern of these professionals, regarding the range of queries, were related to baby food. It is important to highlight that, regardless of the adopted schedule, childcare programs ensure the empowerment of health teams to make changes in the frequency of consultations, according to each child's needs[8]. Respondents were concerned with the quality and length of consultations in order to meet the families guidance needs, especially when it was a preterm patient.

The Brazilian MS recommends that monitoring the baby be arranged with spaced consultations until the child is two years old, with the consultations distributed as follows: one in the 1st week, 1st month, 2nd month, 4th month, 6th month, 9th month, 12th month, 18th month and 24th month [8]. With regard to the follow-up of RN's in risk conditions, MS and the Brazilian Society of Pediatrics (SBP) recommend this occur through multidisciplinary actions, with a supplemental character to childcare, since it does not allow more frequent and close monitoring, through monthly visits in the first semester, bimonthly or quarterly visits from the 6th to 12th month, and quarterly consultations between the 13th and 24th month [9-10]. This interval is adopted because of the consensus in the literature, and because is includes the age groups with the largest number of infant immunizations, psychomotor development milestones, as well as being held during the stages that require larger health promotion guidelines and disease prevention [8, 10].

The Precious Baby Program proposes that risk infants, including preterm with birth weight <1500 g or GA <33 weeks, BE identified in the Statement of Live Birth with a stamp which signals "red face", indicating that the consultation after discharge should be performed by the AB staff within five working days. The recommended interval between consultations are monthly in the first year of life, at the 15th, 18th and 24th months [5].

This systematic monitoring of child growth and development is a strategy that has generated impact in reducing infant mortality, enhancing priority actions related to the Millennium Development Goals (MDGs)[1].

I think the consultation dates proposed by the Ministry of Health hinder us a bit. We can't be paralyzed, there must be flexibility. For example, in regard to weaning, the con-

sultation is six months, but I will meet them again at nine months. After weaning I must monitor the introduction of solid food What is the mom giving this child at home? Who is by the mother's side that will make a difference, and what it isn't us, but a poorly informed person? E14.)

Childcare is meant to follow the growth and development of a healthy baby. If in one of the consults we observe a developmental delay, we anticipate the next visit (E6).

There are a lot of questions. A hurried consult is no use, and in two days the mother will be feeding the baby with cow milk, right!? I like showing them the graph too "look mom, the baby is growing and developing! Breast milk is working!" (M02).

It was observed that most AB professionals agreed with the current proposal by the MS to joint consults with doctors and nurses. They said that every professional has a different approach, which is complemented in a teamwork. The importance of interspersed consultation in order to meet the strong demand of the unit was also highlighted. Multidisciplinary care is differentiated, rich in information, and knowledge exchange benefits the user. Proper communication between the teams in the surveyed reality favored this model, with interconsultation being held whenever necessary. The need for qualification was reinforced for this service, noting that the merged childcare should not be something imposed, but planned, and with training.

These data are opposed to the results of other studies that identified weaknesses in communication and relationships between professionals AB [11-12]. A study on childcare consultations held by nurses identified unpreparedness and inexperience in monitoring the child, reinforcing the need for training through lifelong learning [11]. It is important that health professionals work as a team, and be prepared to monitor the growth and development of children [5,9,13-14].

I think this dynamic is great, specially because the nurse's approach is different from the doctor's. Anyaw, I think alternance of professionals is always good. And we are in constant contact, if she [nurse] is in doubt she can look for me, if I have any doubts I look for her too (M06).

In a normal situation, alternating these consults is interesting, because we work with a population that is unfortunately above ideal. (M07).

It's interesting to alternate consults as long as the professional feels secure to provide child care. It's no use to put a professional who does not feel apt to attend there. One thing is chilldcare and monitoring growth and development, another thing is to identify a problem in the child. A lot of things can go unnoticed (E12).

It was identified that nurses are losing ground during routine visits because of the bureaucratic demands of the unit, which is also their responsibility. The distance of the care nurse is a negative aspect, for professionals who have a multi-service ESF stated that they believe the nurse has a differentiated overview of the patient, which grants distance from the biomedical model, focused on the disease. Emphasis was made on the role of the nurse as a health promoter, carrying out directions and expanding the relationship with the user [11,13].

I blame myself when I see a new precious baby "My God, another one I won't be able to monitor." Today I really don't manage. The support we give is bureaucratic, I guarantee the consultations, and I give them my phone in case they need to contact me. It's too much for us to do at once. I joke that each program thinks that their own is more important than the other, everything is priority. [...] so, what is our real priority? (E12).

The doctor always calls me in to reinforce recommendations. We [nurse] work with recommendations a lot. Despite this doctor that works with me giving a great deal of recommendations, I have worked with a lot of doctors who were focused on the disease. But since mothers connect with us, they ask questions, sometimes even in the hallway (E11).

The lack of ESF teams, which, in the reality studied, had a 54.38% coverage, has resulted in child care visits that are often exclusively with the pediatrician of the network UBS, without ESF. The views on the need to refer the preterm and / or low birth weight baby to a specialist were controversial. There were professionals who referred all of these patients to the pediatrician, and there were those who only reffered thos in real need. Some believed that the pediatrician showed more confidence in the care of these babies, and transfered this confidence to parents. Maybe this user versus AB health professional relationship be strengthened with the expansion of the FHS teams.

The model of care observed is contrary to the National Primary Care Policy (PNAB), which recommends that referrals to the specialties of Family Health Support Centers (NASF) are regulated by the AB teams from the identified demands, and not routinely. Even in cases where the child

is referred to the pediatrician, it is suggested the ESF still monitor this child.[8.15].

The lack of a closer contact between the family and the staff makes the family insecure to follow up their preterm child in AB. A study evaluating the implementation of an ESF in a community identified greater bond between users and professionals and resolution of the demands [12].

I notice that parents prefer for their children to be attended by pediatricians. So much that many come from other neighborhoods to be consulted here. They feel more confident about this professional. I think all units should have at least one clinician and one pediatrician, because there is a difference in the service. [...] And, the pediatrician has a specific approach. (T04),

We usually give preference for the family doctor and nurse, alternating consults according to the gudelines provided by MS. They only forwards to the pediatrician only those who have an abnormality and need care with a specialist (E06).

The data showed that the professional category responsible for carrying out childcare affects the membership or not of the segment in UBS by the community. The difficulty in some cases to keep track of prematurity in the maternity clinic in conjunction with UBS emerged. In these cases, the concern of UBS for conducting an active search and following the family through VDs was highlighted.

The distance between home and the health service, the fact of having more children, the lack of time available and family financial constraints appeared as hindering aspects for parents to take the child to be followed in the two levels of care.

Actually, these babies end up being monitores, a lot of them anyways, by the materity. We end up doing a home visit to know if they are accomplishing anything there. I notive there is a family resistance to keeping the ambulatory and the health center, you know, because sometimes the mother words, she already has dificulties, so she ends up going to just one place, and because they are already seeing here there, she won't come here. (M05),

The recognition, by the professionals interviewed, of the importance of VD in the child's follow-up was unanimous. According to them, with VC it is possible to better observe family conditions, identify potential caregivers, the kind of support the family will need from the UBS, hygiene and abuse wise, among others. The influence that this activity has when favoring the bond with the community and drawing people to UBS was highlighted. Through the creation of the bond, it is possible to establish a link between the responsibility of health professionals and the community.

The deficient availability of cars and the work overload in UBS were considered important deterrent factors for the realization of VDs, requiring investments in this regard.

Studies on the care of children in family health stressed that VD, despite being an old care technology, brings innovative results, and proved to be an important tool for the delivery of health care to the family as it allows a closer proximity to the family environment, the place where the family lives, their daily routine, their culture, their habits and their health care [12-13].

I think the visits are very important, because while the nurse is examining the baby, giving recommendations to the mother, the house situation is already being observed, if there is any risk, what hygiene is like, the care of the family in regards to other children, the relationship between the children and their parents (E06).

The home visit is also important to form the bond. Because families get really happy when we go, than you can get them to follow up in child care (E080.

The staff's concern in performing family care, maintaining the bond and monitoring the child, such as scheduling facilitated consultations, was also highlighted in this process.. Another preoccupation was related to the flowcharts that would guarantee the consults with specialized professionals and continuity of care.

The enigmatic preterm and/or low weight baby and childcare in Primary Health Care

In this category, we identified that the follow-up of preterm and/or low birth weight babies appears to still be a mystery to the AB health teams. The care for this child caused concern, being permeated with doubts and insecurities. Opinions differed on whether that baby needed special care or not, and if they could be compared with a so-called "normal" or born to term baby.

The formar patients of the UN have special needs, regardless of the reason for hospitalization, since they are submitted to specialized therapeutic interventions [5.13].

Sometimes a preterm baby comes in and then insecurity gets us: what then? What do we do? We work with care to normal babies, and I believe it should by special (E01).

What we always recommend to mother is that, from the moment the baby is discharged, it's as if that baby was born at full term. Care will be given as if it was to a normal baby, they won't necessarily need special care, it varies from case to case. [...] one of the things that we see often in preterm babies is that they think the baby is made of glasse, that the baby shouldn't do anything (M03)

The type of care depends on the cse. There are preterm babies that are more agile and smarter than a baby born at term, and there are babies born at term that need more care then a preterm baby. Prematurity in itself does not imply special cares, just because he was born tiny. It will depend on how the baby develops (T06).

Despite all the anxiety that caring for a preterm and/or low wieight baby causes in the health team, most professionals showed good understanding of how the follow-up should be performed, with 45.2% prefering they had some form of in-service training regarding child care. The good performance of the professionals is owed, perhaps, to the fact that 71% had expertise, which shows the interest in keeping themselves up to date. The desire to perfect themselves was verbalized, and in this aspect, the MS recommends that continuous training be an activity that enables professional development, through the identification of critical points [15].

I would like us to have a courrse on how to attend a preterm baby, its peculiarities. I would like to be updates in those aspects, because a lot changes (T02),

The fact that most professionals were aware of the need to use the Corrected Gestational Age (IGC) to evaluate the baby's growth and development, as well as a specific graph for preterm babies was attention drawing. It is known that until 40 weeks of IGC are achieved, we recommend using the intrauterine growth curves for preterm babies, and only after that, use the reference curves of the World Health Organization (WHO) [10]. A proper assessment provides confidence in child care as it detects potential risks early in the child's development. In this aspect, re-hospitalizations and morbidities are avoided, reducing child mortality, as proposed by MDG's[1].

We check the weight, observe the baby's development and use the graph for preterm babies, because we must discount the gestational age at which the baby was born, or else the baby will always be below the expected (T02).

We have to be carful [...] with the weight calculation and the use of this specific graph. I have a graph for preterms that I plastified and wonder around with (M08).

Among the actions that professionals mentioned that act upon the monitoring following the preterm and/or low birth weight baby included: neurodevelopment assessment and possible consequences related to prematurity; the evaluation of anthropometric measurements with use of appropriate graphics; vitamins supplementation due to prematurity, with prescription replacement of vitamins A and D and prophylaxis with the use of ferrous sulfate. The concern of these professionals was highlighted, especially with adequate weight gain, considering that these children are born with low weight and are discharged while still very small, which creates anxiety for the caregivers.

The literature emphasizes that every child with a history of low birth weight should be considered a nutritional risk child and must be accompanied in different ways by the health team, especially in the first year of life [8,11]. It is noticed that child care is still performed according to the medical centric model, biomedical, with guidelines focused on curative care and still fragile when it comes to health promotion [13].

The main guidance provided to the family members focused on hygiene, cleaning the umbilical stump, vaccines, medications, special dietary use such as high-priced milk, use and supply of special materials such as probes, colostomy bag, infusion pump, among others.

The practice of individualized care was noted, with professionals provided guidance addressing the special needs of each baby, their level of severity, length of stay in the UN and level of development. The holistic care, integrated and humanized for the newborn and his family must be a constant for the caregiver staff, and the good relationship favors this practice [14].

The care that I provide and guide are individualized according to the needs of each baby. I usually equip the mother so she encourages the maximum development of the child. If you stop to think about it, there isn't much difference from what I recommend for full term babies, but of course for a pre-term baby we are always more attentive (E13).

The preterm and/or low birth weight baby is still a mistery for AB professionals, but despite the feeling of insecurity, most of the time, professionals proved to be capable of accomplishing their care properly.

The interfaces of the third stage of Kangaroo Care with AB

Emerging from the theme of the MC during the interviews, we identified little knowledge by health professionals of AB on the magnitude of Public Policy. Three professionals reported total lack of knowledge about the method, and the others showed very superficial understanding, limited to skin contact and maintaining a bond, without recognizing the proposed paradigm shift in newborn care that the method encompasses.

Only one professional reported having attended a baby who was stage 3 of MC, however, it is believed that this number should be higher. There was no identification in the patient's records or the Precious Baby's registration about the child's participation in the third stage of MC, with this information being undervalued in the AB's follow-up and care being fragmented between the hospital and UBS.

The third stage of the MC is when the baby, meeting criteria such as minimum weight of 1600g, being clinically stable, with adequate weight gain and caregivers able to perform safe care at home, receive hospital discharge and become outpatients monitored through follow-ups. According to the MS, at this stage, three visits in the first week, two in the second week and a weekly consultation from the third week until the baby reaches a weight of 2,500g are recommended [2]. Although the MS proposes the participation of AB professionals in the third stage of MC [2,9], through consultations and VD, this is still not a reality in most municipalities.

> *I remember that shortly after discharge from the maternity, I asked if he was still doing the Kangaroo Method and she said that as much as possible with her household activities. I know little about Kangaroo Mother Care. I don't know the specific theory of what it is, only about the bond, being warmed by mom. (E13).*

> *I had a training during introduction that talked about what the Kangaroo Method is, something that give the mother and baby closeness, right?! They even made us watch a series of videos that gave us a general idea of what it is. About breastfeeding and the exchange between mother and baby (T07).*

The difficulty of AB professionals in continuing the Kangaroo care and acting in the third stage of the method appears to be related to the limited knowledge they have, which results in insecurity and lack of confidence in their professional abilities. The fragile communication between the hospital and the UBS makes the continuity of MC impossible to be performed in primary care. Therefore, one needs professional training and agreements between the various health care levels for the realization of the third stage of the MC to also be heald in AB.

It should be noted that this issue is also identified as a strategic priority in the Comprehensive Care Policy on Children's Health recently published by the Ministry of Health, which indicates the need for qualified discharge from the maternity RN, linking the mother-baby to AB early on to ensure a coordinated care network for continuity of care [16].

The success of MC at home depends on the support provided by the health team, especially when considering the complex transition that occurs at the time of the hospital discharge [17-18]. It is known that the guidelines of the multidisciplinary team are crucial to family confidence in care.

> *You know it's a method that favors the development of the baby, bonding, affection, assistance in the matter of child development. But here at he unit we can not have this care, but we know it's important, we know the basics right [...] (E03).*

A meta-analysis performed, contemplating the period from 1970 to 2009, included 15 randomized trials with 524 smaller preterm infants of 2000g, showing that the MC is highly effective in reducing severe morbidity, particularly from infections, and significantly reduces neonatal mortality in this range [19]. The systematic review involved 2,751 newborns weighing less than 2300g, and also included 18 clinical trials. It proved that the method reduced the mortality rate [20].

This reduction is associated primarily to the stability of the physiological parameters of the newborn, facilitated by applying the method to greater weight gain, shorter hospital stay and exclusive breastfeeding. From these scientific evidences, the importance of MC in the actions planned for the MDGs is highlighted[1].

Caring for a baby egress from the UN, at home, requires confident family members. Such security is acquired with the support of the multidisciplinary team to address the doubts and alleviate the anxiety of parents. In UBS, among the various thematic guides, the efforts of these professionals to maintain breastfeeding stood out, and 42% were trained in Breastfeeding Strategy and Feeding Brazil (Estratégia Amamenta e Alimenta Brasil).

These professionals consider the difficulties that the mother had to maintain the milk production during the baby's hospitalization, therefore, spare no effort

for breastfeeding to be maintained properly at home as well. Emphasizing the benefits of breastfeeding for mother and child, as well as the correct grasp, identifying difficulties and problems in the breasts, pain or cracking, giving advice on supplying milk in a cup and not offering a bottle or other artificial nipples were suggested. The importance of the maternity's Human Milk Bank support services and the participation of mothers in the MC in the promotion of breastfeeding, as corroborated the literature was highlighted [19].

> *Usually whenit is a preterm, low weight, or has some difficulty in breastfeeding, I schedule a return for as early as possible, even if it's a walk in, exactly so that in a month they won't come and say "I'm feeding the baby with a bottle". (M02)*

> *The babies arrive here at MDV either preterm or low weight, but because they go through the breastfeeding and Kangaroo care, all babies that I have attended so far present a significant weight gain and the mothers are much more confident about breastfeeding (M03).*

Despite the municipality studied having a public maternity, reference to the MC, there is not yes an interface with AB to perform step three of MC. The Precious Baby Program needs to be strengthen strategies to materialize MC in AB, despite its positive results in relation to the risk babies' follow-up.

FINAL CONSIDERATIONS

The results showed that the *Organization of follow-up in primary care,* in the studied reality, consists of a proper relationship between the health team, which favors multidisciplinary care. The consultations, alternated between doctors and nurses, have been identified as a fortunate strategy adopted by MS. However, the need for education and vocational training to carry out this activity was highlighted. VD showed itself to be an empowering strategy in AB childcare, but often hampered due to lack of transportation or availability of professionals. Therefore, investments and studies are to identify strategies on how to enhance this action, as well as awareness of professionals and managers for the encouragement of their practice.

The category *The enigmatic preterm baby and / or low birth weight and his family in Primary Care,* unveiled the preterm baby as a mystery that persists for professionals in AB, who often feel helpless and unprepared to meet this clientele. Despite these feelings, the professionals in general proved to be trained in attending preterm babies, but, this care is still centralized in the biomedical model. Therefore, health promotion actions guided by the principle of integration should be encouraged.

As for *The interfaces* of *the third stage of Kangaroo Care with Primary Care,* in the care of preterm infants and/or low birth weight, this ratio presented itself as timid, and professionals demonstrated limited knowledge on the subject. It takes professional dissemination and training activities on the method, and agreements between the various health care levels for the realization of the third stage of the MC to also be held AB, thereby contributing to reducing child mortality, meeting the MDGs.

The study pointed to the need for investment in AB, in order to ensure broad coverage of the ESF, as this operating model ensures the territorial community, favoring the link between users and professionals and expanding the resoluteness. Upgrading AB's professional staff promotes the strengthening of the relationship between the team and the community, and gives greater capacity to monitor the preterm and / or low birth weight baby. The Precious Baby Program is evidenced as an important action, through service and professional training protocols, serving as a model for the care of risk babies.

Limitations of this study are in the focus of the participants that was established by exclusively pointing out perceptions of health professionals about the care provided to preterm and/or low birth weight babies in AB. Therefore, it is recommended that similar studies, investigating the perceptions of family members and professional's of the UN about this process be conducted.. It is also suggested that new approaches be used to compare the realities discovered, after the AB trains its staff for action in the MC is held.

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Author's address:
Luana Cláudia dos Passos Aires
Rua Urussanga, 800/401, bl. A
89202-400 Joinville – SC
E-mail: luana_aires08@hotmail.com

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