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Original articles

Integral assistance to premature infant: implications of practices and public policy

Assistência integral ao recém-nascido prematuro: implicações das práticas e da política pública

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ABSTRACT

Purpose: to understand how it is to care for preterm newborns, as recommended by public health policy Kangaroo method, from the perception of the professionals involved in the care.

Methods: this is a descriptive study of qualitative design. Interviews were conducted with health professionals on the health care of premature babies. The participants were eighteen health professionals. Of these, three were social workers, four nurses, two speech therapists, two nutritionists, two psychologists, four nursing technicians and a doctor. All respondents were female. The interviews were closed from the saturation of answers as there was no more significant elements. The completion of the interviews took place in the City Health Department, the Intermunicipal Consortium of Health and the Hospital Santa Casa, all institutions of a municipality the state of Paraná. The technique used for data analysis through content analysis, was the thematic analysis.

Results: were listed two thematic topics for discussion: The fragmentation of care of premature and families; Contradictions between the professionals and the established public policy practices. It is considered t hat there is no effective monitoring for premature and question the continuity of care, for comprehensive health care. It is observed that the professionals do what public policy advocates, and value the care and hospital care.

Conclusion: the Misfits are clear in all health services, and then there is compliance with the policy.

Keywords: Health Education; Public Polices; Interdisciplinary Communication; Comprehensive Health Care; Infant

RESUMO

Objetivo: compreender a forma como ocorre a assistência ao recém-nascido prematuro, conforme preconiza a política pública de saúde Método Canguru, a partir da percepção dos profissionais envolvidos na assistência.

Métodos: trata-se de um estudo descritivo de delineamento qualitativo. Foram realizadas entrevistas com profissionais da área da saúde, sobre a assistência à saúde de bebês prematuros. Participaram da pesquisa dezoito profissionais da saúde. Destes, três eram assistentes sociais, quatro enfermeiras, dois fonoaudiólogos, dois nutricionistas, dois psicólogos, quatro técnicos de enfermagem e um médico. Todos os entrevistados eram do sexo feminino. As entrevistas foram encerradas a partir da saturação das respostas, pois não houve mais elementos significativos. A realização das entrevistas ocorreu na Secretaria Municipal de Saúde, no Consórcio Intermunicipal de Saúde e no Hospital Santa Casa, todas as instituições de um município do estado do Paraná. A técnica utilizada para análise dos dados, mediante Análise do Conteúdo, foi a Análise Temática.

Resultados: foram elencados dois núcleos temáticos para a discussão: A fragmentação do cuidado ao prematuro e as famílias; Contradições entre as práticas profissionais e a política pública instituída. Considera-se não haver acompanhamento efetivo para os prematuros e questiona-se a continuidade nos atendimentos, para uma assistência integral. Observa-se que os profissionais desconhecem o que a política pública preconiza, e valorizam a atenção e cuidado hospitalar.

Conclusão: os desajustes são claros em todos os serviços de saúde, e então, não há o cumprimento da política.

Descritores: Educação em Saúde; Políticas Públicas; Comunicação Interdisciplinar; Assistência Integral à Saúde; Recém-Nascido

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INTRODUCTION

The practices of health professionals are based in actions that do not exceed the biological and clinical nature of human beings, which interferes in operations and comprehensive care to the individual. As author[1], fragmented knowledge and hyper-expertize lead to lack of conception of global vision. The author suggests that the ability to perceive the context and the complex was crumbled and, as he says, generating also "ignorance and blindness."

By considering the proposed theme on premature infants in developing countries, prematurity is considered a public health problem due to the high newborn morbidity and mortality[2]. The premature newborn requires specialized care for the survival, which becomes a challenge to staff, parents and the baby.

There are several public policies to care preterm infants and their family. There is the Stork Network as the recently instituted policy, which promotes maternal and child care, including premature and full-term babies, taking care of comprehensive and humane way up to two years-old. However, it was decided in this research to study only the Kangaroo method, a public policy exclusively for premature babies.

According to Ordinance No. 693 of 05.07.2000, the Ministry of Health of Brazil adopts the public policy the Humanized Care for the Newborn with Low Birth Weight (Mother-Kangaroo Method - MMC), " which recommends it and defines the guidelines for its implementation in medical-care units members of the Unified Health System (SUS)"[3].

With this Decree, the Ministry of Health established the Kangaroo Mother Care as a national public policies regarding children's health. This method has emerged as an interdisciplinary approach to better serve premature and his family. The method was created in Colombia in 1979, at the Maternal and Child Institute of Bogotá, by the doctors Reyes Sanabria and Hector Martinez[4]. At the time, there was a shortage of physical and technological resources. There was the realization that there were economic advantages, and improved psycho-affective and physical aspects of the baby.

The method comprises three stages, in which the first two ones are predominantly in the hospital environment and the third stage is outpatient monitoring[3]. In these steps there is a promotional character for care the baby and family[5], promoting family participation and stimulating maternal lactation[3,6]. The position adopted in the method is prone in positioning the baby vertically against the adult's chest[3].

The policies for children become an opportunity to realize legal gains, and were in a citizenship space (against inequality and recognizing the differences); culture (plurality and uniqueness environment) and knowledge (responsibility to the dimension of humanity and universality). It is important that policies committed to children face problems of the human condition, as the difficulty of working with the differences, discrimination, and difficulty in recognizing that what makes the singular subject is the fact of being plural[7].

It is recognized that premature children are in need of comprehensive care for development, considering a care for the physical problems and "interactional" of baby that may occur[8]. With regard to breastfeeding, which is considered a healthy and safe food for all babies[9,10], in anterior studies it was showed that exclusive breastfeeding rates for premature babies in hospital until the sixth months-old are below the recommended by the World Health Organization[11-13] and considering also that the early weaning lead to behaviors such as use of baby bottle[14] and pacifiers in babies[14,15].

The authors believe that in spite of difficulties in breastfeeding of premature baby, it is important that the conduct of the staff and the hospital routine fit to meet the family demands[16] and there is a closer relationship between his mother, his family and staff[17] to breastfeeding may be facilitated and promoted[16].

The professionals have difficulties in establishing the convenient time to start breastfeeding of premature babies [18] and the babies have difficulties regarding the "food function"[19]. However, an accomplished study[20] showed that one of the benefits of Kangaroo Care is precisely to facilitate exclusive breastfeeding of preterm infants.

So, it arises the need to understand how the practices of professionals involved in care are complying with the rules established to provide comprehensive care to premature, as public policy, so that make it possible to meet the needs of the dyad mother-baby need .

This study aimed to understand how it is assisting the premature newborn, as recommended by public health policy Kangaroo Care, from the perception of the professionals involved in the care.

METHODS

The study was approved by the Ethics Committee of UNICENTRO under number 638 824/2014.

This is a descriptive study of qualitative design. Interviews were conducted with health professionals on the health care of premature babies. All participants signed a consent form. Eighteen health professionals participated in this study. From these professionals, three were social workers, four nurses, two speech therapists, two dietitians, two psychologists, four nursing technicians and a doctor. All respondents were female.

In order to keep the identity confidentially, survey participants were identified with abbreviations (P1, P2, P3... P18).

Interviews were closed from the saturation of answers as there was no more significant elements, i.e., the responses were repeated. Inclusion criteria were: health professionals who were involved in caring for the premature baby. Since the exclusion criteria were: Health professionals who were not involved in caring for the premature baby.

The locations of the interviews were the City Health Department, the Inter-municipal Consortium of Health and the Hospital Santa Casa, all institutions in the city of Irati/PR.

The guiding questions were:

- How do you understand the flowchart of expectant mothers in the health service here in Irati?
- With respect to health care for premature babies, what do you understand about what is happening here in Irati?

The interviews were recorded and later transcribed. After this stage, the data were analyzed using content analysis, thematic modality. "The term most commonly used to represent the data treatment of a qualitative research is content analysis" [21].

The technique used for data analysis through content analysis was the Thematic Analysis, which "consists in discovering units of meaning that make up a communication whose presence or frequency mean something to the targeted analytical object" [21].

Thus, it was determined the registration unit, which would be the keyword or phrase; the context unit, which is the delimitation of understanding of the context of the registration unit; the cutouts; the form of categorization; the method of decoding and the more general theoretical concepts that guided the analysis[21].

Therefore, the reports were analyzed in thematic groups. In transcripts of speeches, we used some symbols, like an ellipsis (...), to indicate that there was suspension of the sentence, because of interruption of thought and hesitation of the participants, and we used ellipses between brackets [...] to indicate that some sections the speeches were suppressed in that transcript.

RESULTS AND DISCUSSION

Regarding the interviews, for health professionals, we listed two core themes for discussion: The fragmentation of care to premature and families; Contradictions between professional and established public policy practices.

The fragmentation of care to premature and families

the issue of monitoring premature babies after hospital discharge has emerged in the speeches of professionals. This is important because it is a stage of Kangaroo Care, and the 3rd phase corresponding to the outpatient phase.

P2, P4, P6, P7 and P12 pondered the issue as follows:

"He will always be accompanied in the basic units, because the monitoring and other vaccines will also be in the basic units. So he does not lose touch with the right service. Then he will always have to... the staff is an active search for this child, through community health workers, right? " P2

"[...] But we are doing more here (Municipal Health)… Because there (Inter-municipal Health Consortium) there are other municipalities, so here (in town) we get over here (Municipal Health Department) but the doctor also attends there in the consortium [...]. P4

"[...] When you get here (Inter-municipal Consortium Health) they do the attendance, but the only issue we cannot reach here in the consortium is the question that we are not responsible for the appointment to come from there (Municipal Health) to here (Inter-municipal Consortium Health). " P7

"[...] The doctor prefers to stay with the doctor ("Clinic" of Hospital Santa Casa), because the conducts are different, you know, there's pediatrician of the municipal health with Dr. [...] Then ... only so ... I told you that neither I, weight, vaccine ... those things they do in the office, this childcare, now, we shall say if the baby is cold, if the baby is not sucking well, if they are losing weight, the doctor she would rather meet here ("Clinic" of Hospital Santa Casa),

because she already has the following attending, then mothers have the appointment, then they come on that day, and then they are clear about all doubts of what is happening. " P12

According to the answers, professionals mention the Basic Health Unit (BHU), the Municipal Health Secretariat of the city, the Inter-municipal Consortium of Health and community health agents, as responsible for attending the premature babies after hospital discharge.

P12 mentions the following question: "if the baby is cold, if the baby is not nursing well, if it is losing weight, the doctor prefers to attend here ("Clinic" of Hospital Santa Casa)." It is important to highlight that speech, so as to underline that care for children only occurs when there is disease ("if the baby is cold, it is losing weight"), i.e. the service revolves around the disease, which presents a fragmented attention and care to the baby and family.

Although some professionals suggest where the babies were being attended, there were others who were not sure or did not know where these children would be sent, some reports as follows:

"This care happens… You know… But I cannot tell you exactly who is responsible for this, but I believe it is being done because they (the Health epartment of Pediatrics) have a concern there when the baby comes early for us. " P1

"Here the continuity of care in all areas of SUS is very difficult to happen [...] and the premature baby also does not have ... no ... much less, then, to continue [...]." P9

Based on the speeches, the main points were the not awareness about who or the place where the children were accompanied and the complicated realization of the accompaniments by SUS.

There are again contradictions among the professionals, because while some of them mentioned where children were monitored, others did not know this information.

By considering the public policy recommended for premature babies, it is clearly that the 3rd phase of the Kangaroo Mother Care does not occur because, as recommended by the policy, some actions must be developed at this stage as a complete physical examination in children (degree of development, gain weight, length and head circumference); to evaluate the psychological balance between the child and the family; correct risk situations (inadequate weight gain, reflux signs of infection and apneas); to guide and monitor specialized treatments (eye exams, hearing evaluation and physical therapy) and to direct observation in the scheme of appropriate immunization[3]. And besides, a multidisciplinary team should be involved in this care[22].

Although there is a multi service in town, the Inter-municipal Consortium of Health, the calls do not occur effectively to attend families and the baby and family and to accomplish with the recommendations in politics. And therefore, we observed the drift to which these children are directed, suggesting that these children are "lost" and "luckily" they may be attended and receive minimal monitoring, the basic one, and weighing and vaccinations, since, as said, there is not comprehensive care for babies.

In a conducted study[23] we found that the insufficient number of Basic Health Unit and Teams of the Family Health Strategy prevents the care coverage and monitoring of users on the system. And yet in the same study, in relation to Community Health Agents, they did not report in speeches "the importance of forming bonds of knowledge and mapping of territories with families, identifying the social determinants of health-disease process in its micro areas, etc. "

By reflecting on the weak monitoring of health professionals with families, authors[24] corroborate the issue, according to the findings in their study, the professional interaction with the family is basic, i.e., with quick, short and focused consultations on weight of child. Issues such as everyday experience of parents with the kangaroo position and the baby were not mentioned.

Another problem mentioned by professional P6 about the trimmings of infants was related to the appointments for certain places for this procedure, as reported:

"Well… The municipalities ... They ... the problem of municipalities is the appointment, everything is about the appointment." P6

This problem can be configured as a major obstacle to occur monitoring, because it refers to a faulty operation in the health system and management, which is not covering babies and directing them to continuity of care.

Second[25], health services have an organization of dedicated work in the knowledge of professions and classes "(the coordination of medical staff, nursing,

social workers, etc.)", and as a result, they did not share common goals.

By considering the National Policy of Humanization (PNH) [26], this is linked with the establishment of integrity, a principle that guides the SUS, then, involves all levels of care, and conditions "the idea of linkage between the work processes and the management of health services and resources[23]". Hence the importance of communication is not only for professionals, but it is also for the services.

To occur a better functioning of the service, it is necessary to rethink the way of management as a participatory management is the way to build changes in health practices, in which the service becomes efficient and effective, and it also motivates professional team. "Co-management is a way of managing that includes collective thinking and making, and therefore an ethical and policy guidelines aimed at democratizing relations in the health field" and, thus, for minimizing service malfunction[25].

The problem of directing high-risk pregnancies' babies after hospital discharge, for multi-service (Inter-municipal Health Consortium) was mentioned by P4 and P9.

> *"Actually, if it were only directed to a location, that's right ... if it left the ICU and were there (Health Consortium of Inter), or came here (Municipal Health)… Because we sometimes get lost in few things: we think we are going there (Health Consortium of Inter), and it's not there (Health Consortium of Inter), and we are coming here (Municipal Health Department)… You know… So you understand as well. But here (in town) there are not too many premature babies. There are some babies but it is not like that thing which will run away from your reach."* P4

> *"There are few pregnant women (in the city) with high risk. The most common is the largest ones [...]. There are more babies. That's very difficult, because they are already coming from high-risk, right? The high-risk pregnant women are not forwarded, so consequently there aren't many babies right (reference to premature babies in the city). "* P9

It stands out in the statements the following issues: the non-coverage of pregnant women in the services; the actual city health system, not forward high-risk mothers for specialized service, and no significant number of premature babies in the city.

These notes refer to a health service with serious communication problems and scope, although P2 contradict this perception.

> "We can do it, because it is centered (Municipal Health-Prenatal) right? It would different if it were decentralized… If each unit would meet a pregnant we would not have control. But it is centralized we have this control because we see them every month, and then every 15 days and every week. We can evaluate them in every appointment. We also have doctors here. They are all obstetricians, so they are able to serve these high-risk pregnant women too. It is not a general doctor who is meeting them. " P2

Given the argument of P2, it is observed that this is not real, as there are other reports that are inconsistent with the professional.

The fact that the referral of high-risk pregnant women for the Inter-municipal Consortium of Health, which is a specialized and multi-professional service, does not occur, although P2 report that at Municipal Health Department these services can be guaranteed to pregnant women, there are questions regarding the sufficiency of it, as there is in the city a specialized service, which would be the reason for not using it. According to P9, the pregnant women from that place do not participate in these services, what is considered another failure in care, implying that communication between the health sectors does not occur in the way it should happen. As a result, mothers and babies are not being assisted and ensured for compliance assistance.

As mentioned by P4, the professional suggests that in the city there is no amount of premature that does not allow the scope of the system. This is contradicted in accordance with the Live Birth Information System (Sistema de Informações sobre Nascidos Vivos - SINASC), which points to significant rates of premature births in the city. In 2011, there were 8.72% of prematurity index. It was higher if it is compared to the state of Paraná in general, with 7.23% rate, and in the capital Curitiba, with 7.34% of prematurity index[27]. This is a concern since as professionals and the system cannot provide services and calls required for this population. And besides, through this professional, it was noted a practice which is completely disconnected from reality, as indices show a high incidence of premature births and the professional's speech involved in the system is not consistent with the fact.

P9 mentions certain rivalry in services, which causes this lack of referral of pregnant women for the Inter-municipal Consortium of Health.

"[...] I do not know.... They are here, as a matter... For political issue. Ah it is a "rivalry", you know... and they do not want to send them for us (Inter-municipal Consortium Health), we do not know why… What the consortium... you know... We just hear this [...]". P9

In connection with these rivalries in the service, according to the authors[28], it is a condition that arises from the lack of dialogue, the issue of sovereignty between the staff members, and the disregard of the opinions and knowledge of others professionals. It reflects a break in relations and, consequently, the efficiency of services rendered to users.

Another issue on the referrals of high-risk pregnant women for the Inter-municipal Consortium of Health, for monitoring of infants and high-risk mothers, is that the same pediatrician meet in both health sectors, at the City Department of Health and at Inter-municipal Consortium of Health. P4 reports:

*"In fact, he (baby) come here (Municipal Health), the doctor will see him. If the doctor thinks he should go there (*Inter-municipal Consortium of Health*), she will send us (*Inter-municipal Consortium of Health*), but the doctor is the same one, right? Dr. Monica meets there (Inter-municipal Health Consortium) and here (Municipal Health Department). She sometimes sends some children... She accompanies there (Inter-municipal Health Consortium). And there are other children she attached here (Municipal Health Department)."* P4

The fact that the same doctor has attended in both health services where pregnant women are met creates convenience for both pregnant women and their pediatrician for having appointment in one place. However, this action may not correspond to a well-functioning system, because other sectors do not know why this is happening and why they are not involved in that decision.

Although unfavorable factors in the care of family and babies, it is interesting to note the perception of some professionals across the care of preterm infants, they describe it happens in a proper way, and it is satisfactory. We observed several speeches of the professionals interviewed, highlighting the following reports:

"I believe these babies have been assisted. We can see the concern of pediatrics regarding these babies when they come to us (Municipal Health Department)." P1

"There are so many sectors, there are several sectors… You see… There is high risk pediatrics there, there is also here (Municipal Health Department). There is ambulatory… So the support is good [...]." P4

"[...] So the babies of Neo, I know... They have a very good service, so you know, after they leave here (NICU) [...]." P12

Highlights for these lines are: the babies have been well attended; there is a comprehensive care and there is a good service support to this population.

In the speech of P12, the professional mentions a good care for premature babies because the hospital provides service as NICU and the "Clinic" for monitoring. It seems obvious the positive perception regarding care, for mentioning a service that offers such procedures, however, it is noteworthy to highlight the knowledge of professional regarding the other services that should assist babies, and also the focal point for a only hospital care to be sufficient to meet the babies. The "clinic" of the Hospital Santa Casa was recently organized for a local pediatrician. The service is offered by only a doctor, with no other professionals to meet the mothers and babies, as required by policy.

Although there are positive positions with respect to the health care of premature babies, there were reports of failure assistance, as it is seen in the lines:

"I think... Well… It's necessary to improve basic care, with Family Health Strategy, because nowadays the ESFs are responsible for an area greater than their capacity. So it is necessary to improve it a lot. You cannot do it in a team responsible for an entire neighborhood, a population [...] more attention... A greater investment to primary health care ... is ... medium and high complexity… It would be the minimum right? So, if you have a well-structured primary care you do not need to invest as much in highly complex because the cost would be less." P2

"Actually... The main issue I think is the medical care... It's the care before the baby is born... Well you know ... Mothers go there (Hospital Santa Casa)... They come here (Consortium Health Inter-municipal)… Mothers with high health risk… There is still the issue of these mothers who have health risk and the doctors do not forward them for us here. Because the doctors of prenatal care who must

forward them. [...] I think maybe this assistance is broken right there for ... not be held entirely because of ... this bureaucratic issue." P7

"[...] Well… the complete assistance like the way we've talked… I think it is little [...] In fact this business of multidisciplinary, interdisciplinary work is very new, right? We're struggling to get it right here in the consortium, because before there was nothing, and you know, it is a medical model that our people…" P9

"[...] So, this program has been failed here (Hospital Santa Casa), right? We try to do as much as we can but it's bureaucratic! It is a matter of service... And there is not the place for following care them. So, I believe that when they are here (Hospital Santa Casa) within us we can keep up with, now when they leave here it's not possible to do this last phase [...] then he is discharged… oh I told you this happens: we make the appointment (at the "Clinic" of Hospital Santa Casa), most babies will not be attended until 2 years-old. I believe that to 6, maybe 7 months-old or less, you know… I think this program has a lot to be done yet, because I think it's... Here is the only hospital that makes it… There's ICU here. We are trying to do [...] But I think there is the issue of following care, when is here (Hospital Santa Casa) we can do it but the worse it's when they got discharge. " P12

"I think in fact not only for premature babies, but for general it's been failed. We don't have a pediatrician demand in the city because we do not the same support... I'm not only talking in premature, but in general, the baby got discharge and we do not have a pediatrician who is available, especially in public health, right? To get an appointment in the Municipal Health is time consuming, and they say they do not have a pediatrician, and there has to be only a general practitioner, you know… so I think this following assistance is failed in public health, at Municipal Health." P16

"It is really complicated to answer that, right? Because there are cases with failure that should have a better care with more attention to certain facts, and they have complications that could be prevented, so they come here (Hospital Santa Casa) right? There are so many cases that they've been improved enough, so… you know… there are still more failures. Failures which is not in order to where they are from, but perhaps about the prenatal, maybe a better care of the doctor ... to ... have seen some ... something like that … It's complicate to talk about it (laughs). In this sense as well, I don't know... (laugh). " P18

The perception concerning the care for babies has drawbacks for these professionals. Arguments as investments in primary care in order to stop future problems and service failures and bureaucratic issues are part of their speeches.

These findings can be corroborated with the literature[29], which argues that the centralized management models for communication follows upright manner, that is, "they give orders and you obey them", and, moreover, it is bureaucratized and decreased the "voice of order" and "noise of halls", which determines the fragmented and alienated labor. Decisions are made by a few people, and away from other workers to plan and evaluate their actions. As a result, "the staff do not know each other, the services they do not communicate with each other and professionals do not know the reality of the territory in which they work or the results of their actions."

Regarding the mentioned bureaucratic issue, it is considered to be a deterrent for the service to work in proper rhythm, however, the authors[30] point out that the problem can not only be bureaucratic, structure and technical, but rather a "matter involving attitudes, behaviors, values and moral and professional ethics. "

In addition to this negative view about the care, there were professionals who blamed mothers for the care not to be properly done, according to the speeches:

"Well… I think there is the care. Sometimes there is a little, it depends on mothers' resistance… you know… it's like that! I'm not going there because it's okay... because both the consortium ... the consortium nowadays, at the inter-municipal consortium there is a nutritionist, a physical therapist, a psychologist. There are so many specialties that can care this child… So, there is so much work [...] Well, you know... It's what I told you… Sometimes mothers have some resistance, they think the child is well... They think they do not need because the baby is fine, she thinks so ... I'm not going, he is better… But it has been improved enough, so that how much it has decreased, you know, the mortality rate. " P4

"[...] And there are some mothers that not to take the situation too seriously right? [...] Mothers are some

lax so they have no idea what being a mother at high health risk, as I told you, hence they think it is difficult to come here. There are some municipalities that are so distant so they have to come, stay all day, you know, they just come back in the afternoon, for home. So there are some mothers who do not come to see the doctor, they miss the appointment, and they even ask for the doctor: "doctor, I want to discharge… it's very difficult because I have a little child and I have to leave him at home"… you know, there are these kind of social situations, so diverse, that end up joining. So sometimes the mother sacrifices a little and, she suddenly got kids at home." P5

"[...] She (mother) still does not see the importance of other professionals, it is a lot of clinical care, doctor, doctor, doctor." P7

Resistance, neglect, abandonment and lack of awareness of the importance of a multidisciplinary team to care for the babies were features placed to mothers so that the assistance was not happening correctly. This fact leads to think about the matter of being more comfortable judging mothers at no compromise in care, than look for professional bias. It is thought that the problem settles in both directions. It is believed that a failure entails another. The system is disorganized, with strong attacks and disagreements. At that time it is easier to blame the other, than to ascertain the service itself and the management.

Regarding the mother does not consider important the care of other professionals, and consider healthcare as sufficient, it is due to the lack of a centralized place that meets the mothers and babies in a multidisciplinary way. What is observed in assisting babies is the only medical care. In the only health service with a multidisciplinary team in town there are problems in referral of mothers to the site due to bureaucracy or lack of communication between sectors. As a result, they need to look for another service, and this will probably have medical appointments.

It should be noted that there may be other reasons why mothers are not taking the babies for consultations, according to a conducted study[31], the mothers reported difficulties in leading their children to medical appointments, because they live in remote locations, spending on transport and leave early in their homes.

There is another issue found, being a negative factor for a complete assistance on the medical model, named by respondents:

"[...] actually the health, beyond the doctor, we should have more active professional that they cannot just care at the time of taking the child right? To being there directing everything [...] because they are accustomed to receiving everyone and... Weigh, measure, consult and that's all, right? This is the basic assistance that we have, what is used here nowadays... (Inter-municipal Consortium Health) It is a differential right? So they are used to do it, they weighed, measured, checked and leaves, so... there is ... is ... is much much barrier… you know, they have resistance." P8

"[...] So we're looking to take the focus for pediatrics out, and also the medical model, which is important, we know it's right ... but to focus on it too, right? [...]." P9

The biomedical model is still one of the obstacles in the way for comprehensive care.

It is a model which has a mechanical view of the individual body, which is designed with a machine combined with parts which are interrelated. So when there is a disease, this is perceived as a mismatch in somewhere in the body, and then the necessary knowledge is fragmented, represented by disciplines[32].

The practice of demand for medical care when someone is sick prevails in our culture. This follows from the "impregnated biomedical model" in the conception of users, i.e. they "centralize their needs in the doctor." This attention mode has always existed in the health services, i.e. "what it had to offer for a long period of health history in Brazil, still rationally and scarcely, were medical services and, on them, they have a greater appreciation[23]". Thus, according to the data from this survey, the assistance shall focus in this work and also with the concept that is a sufficient assistance.

However, the subject is not a "pile of parts," he is a being who has history and is part of society. Thus, the practices should be directed to the individual and the community, respecting the dignity of the human[33].

For health care, not only the health care needs to include new work processes and professional practice, requiring from health professionals the "expanded conception of health", to transform practices[34].

Another major difficulty in the system is to monitor pregnant women and babies to continue the monitoring of the dyad and not get lost in the system. P5 and P10 report:

"[...] We are looking for a way to have a control over this, because I think it's like… you know... The

children left the hospital; they had no problem, so [...] they are monitoring these children, because if they did not bother it's not a problem. They did not have any health problems, so that's ok ... and that's not good, because sometimes the mother did not bring it, that does not mean that the child is not having problem. [...] By these issues that the mother, she does not have much ... much awareness, she thinks it's not necessary and then... There are not enough professionals to monitor, right, so what happens when ... when the urgency, then they go.... to the hospital, and then most of the time, you know, it's late. " P5

Seeking in this monitoring system, there was still, as P5's speech, situations with mothers who do not go through the pre-natal system:

"No ... not everyone comes, no ... I've noticed those cases that arrive and already have a consultation and... They will have the birth right, then ... then... it's difficult then we go there after the baby is born, we visit it, see if it's okay, but there is not the following care, so you know, it is for the municipality to continue this. So, I cannot tell you how they are doing. " P5

This lack of monitoring with respect to pregnant women and care for babies is a reflection of the lack of a proper functioning of the management and then on assistance. It is the co-responsibility in/for health services, where there seems to be involvement of professionals and managers in the care of individuals, that is, no one is responsible for anyone, and practices are based on "meeting by meeting" does not committing effectively with individuals and sectors. The misfits are clear in all areas, and then, there is compliance with the policy.

Contradictions between the practices and public policy

Another point that emerged from interviews was the knowledge of professionals on public policy for premature babies, as following speeches:

"It's that close to the mother, that is... the issue of ... of .... to be near the mother's breast... that ... that .... That... as it was a vest that the mother has the child close to her... I ... I guess that's it." P1

"I heard about common sense on a TV report… common sense ... but theoretically thinking it is a right connection method, which is essential for the baby. ... He... prioritizes mother-infant contact, basically this, right? And that comes from meeting with the question of breastfeeding, contact, eye to eye, skin to skin. We know the basics, right?" P3

"Ah, well ... What I've heard is not so much, you know… I think ... it's a right program that was released by the government. I think it's that! It was what I understand, that is still being implemented right? I do not know if there is already here (in town), I've never heard, I've heard about it on internet, by things we see but I think there isn't here (in town). I think it has not been implemented yet, so it's something that is still been starting... right ... so I do not know well to tell you for sure exactly how it is this program because here (in town) we do not have it. " P5

"[...] I think so, like... I am Neo's mother (she is referring to the son who was born prematurely), then it is ... the strengthening of the bond skin to skin, I think it is fundamental and essential to the progress of treatment. Yeah ... I think everything they do benefits the mother-child bond, I think it's worthy for. In this ordinance, if I'm not wrong, it is 793, right? They have been spoken a lot about humanization, they say it is ... the mother kangaroo design [...] I just think that family participation before that ordinance was that closed sector, only the staff could enter, the baby was there, and the mother use to be desperate. I know because I speak from my own experience, and we did not have this openness, this freedom to know what it is, which is not a simple language anymore, right?" P11

"[...] I understand that how he brings an increased bonding between mother and baby, because you ... if he is there, it's ... in the incubator, that's so good that he feels the mother's smell, but when he in his mother's lap, he has one more bond with her right? He will feel ... the smell ... the heat… So we do with babies and about whom with high health risk, we get the whole team right near [...]. For the baby we see that his evolution is much higher when he is there because he feels her mother's warmth. So I think the kangaroo mother method is very good [...]. " P12

"[...] The importance of humanization is ... the importance of mother and child bond, right? It is a very important thing." P13

"[...] So it is a method that favors the bond of mother-baby [...] To favor the linkage, that's proved to decrease quite right, the... favors the rehabilitation of the baby, the contact with the mother… it's ... As if it were a natural incubator, it is all the heat it goes to the baby. And this bond also favors the rehabilitation of the baby, and then as if there were three phases, prenatal care involves specialized care to the baby, and the 3rd phase would be the clinic... the method." P14

"[...] I see how the mother kangaroo care provides even more the baby's recovery, some cases that we are already caring in Neo, here mothers spend more time with the baby in her lap, all ... the strengthened bond, the recovery of this baby, diet acceptance, this involvement, both as motor and neuro, the method streamlines a lot [...] So I think the Kangaroo Mother Method greatly benefits the baby and even to calm her mother, because she sees it there all the time, she is near her child and may ask questions with all professionals who come there." P16

"[...] We do in the same bed, on the side... each mother next to her baby, near the incubators, near the baby cribs [...] this involves the whole staff because it is something that we have to check all the time to see if the baby will not destabilize, but it is pretty cool as well. [...] Despite all the difficulties, there is a very large bureaucracy to deploy the right method here; I do not know other places and how it works in other places, only on Internet that people can see this, on the videos [...]." P18

On professional's speeches there has been prevailed the issue of maternal bond with the baby and the benefits that Kangaroo Mother Care can bring to the dyad. On the reports it was noted superficial lines that are marked by hospital policy bias. As public policy, the method occurs in three phases, the first two ones occur in the hospital and outpatient follow-up is the 3rd phase. Professionals do not mention this last phase in the speeches, except P14, which makes visible the little knowledge about politics.

Before concise reports about politics, it is observed that the professionals do not know what it recommends, and value the care and hospital care. So, this can favor for it not to be met in full. In the method, the first two phases are at the hospital, however, the outpatient stage was set for that care became full because there are issues beyond the hospital bias to take care of the family and premature. There's also point out that as a result, contradictions occur in professional practice and what is established in the policy, because if they do not even know the policy, there is no way to apply it and make it a reality in the health services.

Considering the above, on the hospital bias, it is a fragmented care for users, which means realizing the individual who have a body with physical problems, and also "without subjectivity, without intentions, without will, without desire." Therefore, these aspects are not considered to fully take care of the family and baby and comply with the policy, "consecrating the construction of care modes focused on procedures" [35].

Although professionals are unaware of the policy, many professionals pointed to the benefits it provides. The authors[36] also mention in their study about the importance of the method as a form of therapy that improves the baby health and the interaction with parents and family, providing numerous benefits for family members and for the baby who needs special care.

Given the facts discussed, it takes into account that the training of health professionals, to influence public policy happen and a new form of care are made.

Over the years, some strategies have been drawn up so that there was restructuring and humanization in health care, of which we highlight the "Family Health Strategy, the National Policy of Humanization, the Humanization Program of Prenatal and Birth (PHPN), among others. "The goal of these strategies was to provide change in the healthcare model, including SUS principles and guidelines, comprehensiveness in health care. Despite these measures, the formation of professional is removed from the form of a comprehensive care. What is noticeable is insufficient training for the changes instituted in practice, and also a great need for "lifelong learning" to modify the professional performance, and thus to strengthen the health care in SUS[37].

For health professionals, the way in which the work takes place in everyday life, there is lack of incentive to make a critical reflection of reality in order to produce new perspectives to everyday issues, as the curriculum in the courses are prepared in a way that little assist in resolving these issues, resulting also in a disregard of the learning from their own experience in service[32].

The training of professionals is just one of the items that prevent the realization of public policy for premature infants. Vocational training geared towards the NHS and also directed to the integral care need to have a change in world view that reflects the way

to understand patients, their suffering and their reality. Thus, this comprehensive moves towards the solution of problems affecting the individuals[32].

It remains to consider the expertise of health professionals, which creates a better preparation and ability to care for the patient in order to cure. However, as a consequence, the uniqueness and subjectivity of the patient have been left unattended, such as beliefs, culture, feelings, due to something in the body that is manifesting disease and the care with quality and humanized lose espace[38].

The authors[39] argue about the need for health care students know the health model in Brazil, the SUS, in order to understand the functioning of the system, to cause reflections, to contribute to the multidisciplinary and interdisciplinary actions.

Public policy for premature infants was created precisely to break this fragmenting care and discipline, and thus to make room for the humanization in this process. Unfortunately, the training of health professionals did not follow this paradigm shift in care, and therefore we observed insufficient practice to care for the baby and the family. The conception of human being and care, bureaucracy, training, management, finally, various components are misfits and, as a result, there is no compliance with the policy, and individuals suffer because of a health system that does not meet its demand .

A policy should not be exercised only by the will and initiative of "government and/or institutional bodies", but it is necessary the interests of everyone, that is, those who are linked to users and professionals, which exposes their work and actions, the peculiarities of the health service being made possible for populacion[40].

CONCLUSION

Public policy for preterm was established to transform the way of care, and thus to make room for the humanization in this task. Health services are structured by fragmented form of care, and it currently perpetuates. As a result, families and babies receive focused assistance in technical procedures and only when there is illness, not being fully assisted, since often their real needs do not receive attention. They point out the large discrepancies found between knowledge and practice. The controversial speeches of professionals and between different services were outstanding. The system is disorganized and is currently experiencing a great imbalance in all areas, which caused the discrepancies found. Disciplinary training is a major obstacle to encourage an interdisciplinary approach, and thus to corroborate what the Kangaroo policy recommends on a comprehensive care for family and the baby.

As Kangaroo Method is a national public policy that is focused on the health of premature, it is considered as an event that encourages everyone to move, which causes changes in the attitudes and thoughts of everyone who is involved. It includes not only public policy or law but also alludes to the conscience of each person in their personal and professional commitment.

REFERENCES

1. Morin E. A cabeça bem-feita: Repensar a reforma – reformar o pensamento. Rio de Janeiro: Bertrand Brasil; 2003.
2. Torati CV. Política de Atenção ao recém-nascido prematuro*:* Morbidades respiratórias e neurológicas [dissertação]. Vitória (ES): Escola Superior de Ciências da Santa Casa de Misericórdia de Vitória; 2011.
3. Ministério da Saúde (BR). Portaria nº 693/GM, de 5 de julho de 2000. Regulamenta Norma de orientação para implantação do projeto canguru. Diário Oficial da União. 6 jul 2000; Seção 1:15.
4. Cruvinel FM, Pauletti CM. Formas de atendimento humanizado ao recém- nascido pré-termo ou de baixo peso na Unidade de Terapia Intensiva Neonatal: uma revisão. Cad Pós-Grad Distúrb Desenvol. 2009;9(1):102-25.
5. Furlan CEFB, Scochi CGS, Furtado MCDC. Percepção dos pais sobre a vivência no método mãe-canguru*.* Rev Latino-am Enfermagem*.* 2003;11(4):444-52.
6. Maia FA, Azevedo VMGO, Gontijo FO. Os efeitos da posição canguru em resposta aos procedimentos dolorosos em recém-nascidos pré-termo: uma revisão da literatura. Rev Bras Ter Intensiva. 2011;23(3):370-3.
7. Kramer S. Infância, cultura contemporânea e educação contra a barbárie. Rev Teias. 2000;1(2):1-14.
8. Crestani AH, Souza APR, Beltrami L, Moraes AB. Análise da associação entre tipos de aleitamento, presença de risco ao desenvolvimento infantil, variáveis obstrétricas e socioeconômicas. J Soc Bras Fonoaudiol. 2012;24(3):205-10.
9. Medeiros AMC, Bernardi AT. Alimentação do recém-nascido pré-termo: aleitamento materno, copo e mamadeira. Rev Soc Bras Fonoaudiol. 2011;16(1):73-9.

10. Venson C, Fujinaga CI,Czluniak GR. Estimulação da sucção não nutritiva na “mama vazia” em bebês prematuros: relato de casos. Rev Soc Bras Fonoaudiol. 2010;15(3):452-7.
11. Czechowski AE, Fujinaga CI. Seguimento Ambulatorial de um grupo de prematuros e a prevalência do aleitamento materno na alta hospitalar e ao sexto mês de vida: contribuições da fonoaudiologia. Rev Soc Bras Fonoaudiol . 2010;15 (4):572-7.
12. Menezes MAS, Garcia DC, Melo EV, Cipolotti R. Recém-nascidos prematuros assistidos pelo Método Canguru: avaliação de uma coorte do nascimento aos seis meses. Rev Paul Pediatr. 2014;32(2):171-7.
13. Brusco TR, Delgado SE. Caracterização do desenvolvimento da alimentação de crianças nascidas pré-termo entre três e doze meses. Rev CEFAC. 2014;16(3): 917-28.
14. Silva WF, Guedes ZCF. Tempo de aleitamento materno exclusivo em recém-nascidos prematuros e a termo. Rev CEFAC. 2013;15(1):160-71.
15. Granville-Garcia AF, Lins RDAU, Oliveira ACB, Paiva SM, Sousa RV, Martins V et al. Fatores associados ao desmame precoce em Hospital Amigo da Criança. Rev Odonto Ciênc. 2012;27(3):202-7.
16. Pereira LB, Abrão ACFV, Ohara CVS, Ribeiro CA. Vivências maternas frente às peculiaridades da prematuridade que dificultam a amamentação. Texto Contexto Enferm. 2015;24(1):55-63.
17. Santana MCCP, Goulart BNG, Chiari BM, Melo AM, Silva EHAA. Aleitamento materno em prematuros: atuação fonoaudiológica baseada em pressupostos da educação para promoção da saúde. Rev Ciênc. Saúde Colet. 2010;15(2):411-7.
18. Fujinaga CI, Moraes AS, Zamberlan-Amorim NEZ, Castral TC, Silva AA, Scochi CGS. Validação do Instrumento de Avaliação da Prontidão do Prematuro para Início da Alimentação Oral. Rev Latino-am Enfermagem. 2013;21:140-5.
19. Moreira CMD, Cavalcante-Silva RPGV, Miyaki M, Fujinaga CI. Efeitos da estimulação da sucção não nutritiva com dedo enluvado na transição alimentar em recém-nascido prematuro de muito baixo peso. Rev CEFAC. 2014;16(4):1187-93.
20. Almeida H, Venancio SI, Sanches MTC, Onuki D. Impacto do método canguru nas taxas de aleitamento materno exclusivo em recém-nascidos de baixo peso. J Pediatr. 2010;86(3):250-3.
21. Minayo MC. O desafio do conhecimento: Pesquisa qualitativa em saúde. Rio de Janeiro: Hucitec; 2004.
22. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Atenção humanizada ao recém-nascido de baixo peso: Método Canguru/ Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. – 2. ed. – Brasília : Editora do Ministério da Saúde, 2011.
23. Pan BB. Os sentidos da humanização nos relatos dos trabalhadores de uma Equipe da Estratégia Saúde da Família [Trabalho de Conclusão de curso]. Irati (PR): Universidade Estadual do Centro-Oeste. Curso de Fonoaudiologia. Departamento de Fonoaudiologia; 2014.
24. Rockenbach CL, Santos TGD. A Terceira etapa do Método Canguru no discurso das famílias [Trabalho de Conclusão de Curso]. Santa Catarina (SC): Universidade Federal de Santa Catarina. Curso de Enfermagem; 2009.
25. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização. HumanizaSUS: gestão participativa: co-gestão / Ministério da Saúde, Secretaria de Atenção à Saúde, Política Nacional de Humanização. – 2. ed. rev. – Brasília: Editora do Ministério da Saúde, 2009. 20 p.: il. – (Série B. Textos Básicos de Saúde).
26. Brasil. Ministério da Saúde. Secretaria Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: Política Nacional de Humanização: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS. Brasília: Ministério da Saúde, 2004.
27. Brasil. Ministério da Saúde. Sistema de Informações sobre Nascidos Vivos - SINASC. Brasília: Ministério da Saúde, 2014.
28. Pereira ESSL, Silva ACCD. Impactos das mudanças no processo de trabalho dos profissionais de saúde: O que diz a literatura. Rev Enferm. Contemporânea. 2013;2(1):1-14.
29. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS. Redes de produção de saúde / Ministério da Saúde, Secretaria de Atenção à Saúde, Política Nacional de Humanização da Atenção e Gestão do SUS. – Brasília: Ministério da Saúde, 2009. 44 p.: il. color. – (Série B. Textos Básicos de Saúde).

30. Villa VDSC, Rossi LA. O significado cultural do cuidado humanizado em unidade de terapia intensiva: “Muito falado e pouco vivido”. Rev Latino-am Enfermagem. 2002;10(2):37-44.
31. Siqueira MBDC, Dias MAB. A percepção materna sobre a vivência e aprendizado de cuidado de um bebê prematuro. Rev Epidemiol. Serv. Saúde. 2011;20(1):27-36.
32. Araújo D, Miranda MCGD, Brasil SL. Formação de profissionais de saúde na perspectiva da integralidade. Rev Baian. Saúde Pública. 2007;31(1):20-31.
33. Silva FVD, Menezes MDGAD. Formação profissional e humanização dos serviços de saúde. Rev Formação. 2002;2(5):59-74.
34. Marques CMS. As necessidades do Sistema Único de Saúde e a formação profissional baseada no modelo de competências. Rev Formação. 2002;2(5):15-27.
35. Merhy EE. Engravidando palavras: o caso da integralidade. 2005. [Acesso em 31 jan 2015]. Disponível em: http://www.uff.br/saudecoletiva/professores/merhy/capitulos-06.pdf
36. Santana JCB, Assis APDO, Silva CCD, Quites HFDO. Método mãe canguru e suas implicações na assistência: percepção da equipe de enfermagem. Rev Enferm. 2013;16(1):38-48.
37. Batista KB, Gonçalves OS. Formação dos profissionais de saúde para o SUS: significado e cuidado. Rev Saúde Soc. 2011;20(4):884-99.
38. Bolela F, Jericó MDC. Unidades de terapia intensiva: Considerações da literatura acerca das dificuldades e estratégias para sua humanização. Esc. Anna Nery Enferm. 2006;10(2):301-8.
39. Alves LVV, Cardoso LS, Dimkoski EA. Percepção do programa saúde da família a partir de estagiários do projeto VER-SUS –vivências e estágios na realidade do sistema único de saúde. Rev Fam. Saúde Desenv. 2005;7(3):266-71.
40. Backes DS, Koerich MS, Erdmann AL. Humanizando o cuidado pela valorização do ser humano: Re-significação de valores e princípios pelos profissionais de saúde. Rev Latino-am Enfermagem. 2007;15(1):34-41.