LUMEN ET VIRTUS

Follow-up of premature newborns in Primary Care

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ABSTRACT

Introduction: Prematurity is a public health problem that currently affects about 10% of children born in the country. Primary care health teams play a fundamental role in the monitoring of premature newborns, providing comprehensive assistance and differentiated care to these babies. Objectives: To know the perception of nursing professionals who work in primary care (PHC) regarding the care of premature newborns discharged from the neonatal intensive care unit. Methodology: This is a cross-sectional, exploratory and descriptive study, with a qualitative approach.
Results and discussions: Data collection was carried out with nurses working in Primary Care Units in 37 municipalities in the interior of the State of Rio Grande do Sul (RS), whose estimated population, according to the 2010 IBGE Census, is 313,453 inhabitants. After data collection, the answers were analyzed according to Bardin's Content Analysis (2016), and thematic categories were constructed. The aim of this study is to learn about how premature newborns are followed up in primary care and to identify the difficulties faced by professionals in caring for this population.
Conclusion: As benefits of this research, it is understood the importance of discovering the difficulties faced by nursing professionals in the care of premature newborns in Primary Care, so that it can contribute to the improvement and perception of the problems faced by this professional class.

Keywords: Newborn, Prematurity, Primary Health Care, Public Health Nursing.

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INTRODUCTION

According to the Ministry of Health (MS), babies born before completing 37 weeks of gestation are considered premature and, in Brazil, approximately 10% of these infants are born prematurely (BRASIL, 2017). In Rio Grande do Sul, 14,628 premature births were reported between the 32nd and 36th weeks of gestation, according to DATASUS data from 2018 ((BRASIL, 2020). In this sense, the World Health Organization - WHO (2018) informs that, every year, about 30 million babies are born prematurely, causing low weight and illness in the first days of life; It also shows that approximately 2.5 million newborns (NBs) died in the first 28 days of life, 65% of which were premature and most of them due to preventable causes.

In this perspective, the United Nations Children's Fund - UNICEF (2018) points out that more than 80% of deaths of premature newborns are caused by complications during pregnancy or infections such as pneumonia and septicemia. Also according to UNICEF (2018), these deaths can be avoided with proven solutions such as breastfeeding in the first hours, contact with the mother's body, good nutrition, among others. However, many of the surviving premature babies suffer from some form of lifelong disability. In particular, learning-related disabilities and visual and hearing problems (WHO, 2018). According to Santos (2012, 187-189), premature newborns have difficulty breathing due to a deficiency of pulmonary surfactant, causing immaturity of the respiratory system, in addition to the immature immune system exposing them to infections.

For Klossoswski et al. (2016), health services often work care in a fragmented way and only around the disease and technical procedures, leaving the real needs of families in the background. To this end, the follow-up of child health care should be improved with a view to supporting premature newborns and their families, in addition to care in the neonatal period, extending it to the extra-hospital moment, aiming at a higher quality survival for these babies (VIEIRA; MELLO, 2009). Many professionals, however, feel insecure in the management and longitudinal follow-up of premature newborns and end up looking for instruments and unofficial parameters as a theoretical basis (BUCCINI et al, 2011).

In view of this, Gubert et al (2015) state that the actions of the Family Health Strategy (FHS) teams need to include the control of diseases prevalent in childhood, the encouragement of breastfeeding and dietary guidance and immunizations. In this regard, Solano et al. (2019) state that the involvement of the FHS teams has been fundamental in the monitoring of premature newborns, as they guarantee comprehensive care after discharge from the Neonatal ICU. Molini-Avejonas et al. (2018) also show that, with regard to the follow-up of at-risk babies, Basic Health Units with ESF have a higher number of consultations carried out compared to those that are not included in this modality; however, they emphasize that there is a divergence in the number of consultations that the Ministry of Health has for the effective follow-up of premature newborns, that is, that there

are flaws in the records of these follow-ups.

In this sense, care for low birth weight and preterm newborns should take place through home visits, as an instrument to bring users and the primary health care (PHC) service closer together, valuing the family as a unit of care, as a partner and understanding the context in which it is inserted, a necessary condition for the continuity of care at hospital discharge (SOUZA & COSTENARO, 2016).

Considering that the Primary Care nursing team is part of the entire process of child health care, especially for premature newborns, it is understood that it is extremely important to know how premature newborns discharged from the neonatal ICU follow up from the hospital discharge. The objective of this study was to know the perception of nursing professionals who work in primary care (PHC) regarding the care of premature newborns discharged from the ICU.

METHODOLOGY

This is a cross-sectional, exploratory and descriptive study, with a qualitative approach. The project was approved by the Institutional Ethics Committee, under opinion no

4,481,535 and the rules of the National Health Council (CNS) Resolution No. 466, of December 12, 2012, for research involving human beings were complied with. To answer the question of the present study, data collection was carried out with nurses who agreed to be part of the study and working in the Primary Health Care Units of 37 municipalities in the interior of the state of Rio Grande do Sul (RS), whose estimated population according to the 2010 IBGE census is 313,453 inhabitants.

The inclusion criteria were to be in service for at least six months and who had already attended or accompanied a premature baby, the exclusion criteria were nurses who were on leave or on vacation during the data collection period.

Data collection took place from February to April 2021, by sending an email to the nurses of the health units, inviting them to participate in the research. After acceptance, a new email was sent with the link to access the Google form (*Google Forms*) for the participants to answer the questions: seven (7) questions to characterize the informants and four (4) questions that meet the objective of the study.

The collected data were analyzed based on Bardin's Content Analysis (2016), and these were collected, transcribed and gathered by compatible focal points. The thematic categories originated through the focal points that sought to present the results and their respective discussions. To preserve the identity of the informants, the letter E (referring to nursing) and number were used, according to the order in which the answer was sent.

RESULTS AND DISCUSSION

In this section, the results and discussions inherent to this study will be presented. Nine nurses working in the basic health units of the 16th Regional Health Coordination of the State of Rio Grande do Sul participated in this research, all of them female, with ages ranging from 27 to 37 years (four) and between 41 and 51 years (five). As for the time since graduation, it ranged from 3 years (one informant) and from 12 to 21 years (eight informants).

The length of work in public health ranged from one to five years (three nurses) and from 10 to 20 years (six nurses), and the length of work in the reference unit of this study varied from 1 to 6 years (five participants) and from 7 to 17 years (four participants). Regarding the classification of the units, seven are Family Health Strategy and two units do not fit into this modality.

Of the informants interviewed, seven of them have some specialization in different areas and two have none. The areas differ between public health, family health, mental health, collective health, primary care, oncology and health management. Regarding childcare training, only three nurses reported having received some type of training, but of the three only one of them mentioned specific courses in the area of childcare.

The information is presented through thematic categories, the first being entitled "*Perception of specific care for premature newborns in the basic unit*", and the description of nurses' perceptions is recommended in the light of authors. The second category was named "*Family and neonatal ICU: communication and referrals for the follow-up of newborns in primary care*", which describes the referrals of the family to primary care and the communication between the health network. And, finally, the third category entitled "*Care for premature newborns, carried out/guided in their primary care and the main facilities x difficulties*", which describes the care provided by nursing and the main obstacles.

PERCEPTION OF SPECIFIC CARE FOR PREMATURE NEWBORNS IN THE PRIMARY CARE UNIT

In this category, the results and discussions inherent to the nurses' perceptions will be presented in the light of authors, so that the reader can identify the scenario of nursing performance in the follow-up of premature infants in primary care.

Through the analysis of the statements, it was possible to identify that the nurses mentioned the care of the premature baby from the monitoring of growth and development, as well as the redoubled care, as can be seen below:

> My perception is to follow the growth and development with regular consultations with pediatricians; monitoring the specific vaccination schedule for premature infants, home visits by the ACS and the health team, psychological support for parents. (E1)
>
> My perception regarding the specific care provided to premature newborns in the primary

> care unit is that these patients should be cared for with extra attention and that the primary care team needs to know in detail the clinical history not only of the birth of this newborn, but also of the follow-up and complications during prenatal care and during their hospitalization in the intensive care unit. so that childcare care can be designed that meets the individual needs of each premature newborn, thus ensuring comprehensive and continuous care for both the patient and his family. (E9)

The modern world has brought with it technological advances and significant improvements in healthcare. In the field of neonatology, these discoveries enabled a longer survival of premature newborns. Despite this, there are still possible morbidities faced by these children during the growth and development process (FERRAZ et al., 2010). According to the World Health Organization (2012), however, prematurity is still the second leading cause of death for children under five years of age. Many of these deaths could be avoided with simple measures such as the use of antibiotics, antenatal corticosteroids, nitric oxide, surfactant, and high-frequency ventilation.

As described by Rugolo (2005), premature newborns tend to have very frequent cognitive problems in their first years of life and at school they may have educational difficulties. Likewise, the growth of these children is usually marked by a smaller height and weight than expected for their age, which accompanies them until adolescence. The same author also shows that babies born prematurely can have a normal life, as long as they are accompanied in the correct, continuous and multidisciplinary way.

The interview also brought important statements about the follow-up of premature newborns being conducted by the individualistic and only curative model, focused on the medical figure only. The importance of training professionals on the care of this population is also highlighted, since most nurses do not receive any training for the care of premature children.

> Perception that the consultation continues to be centered on the biomedical model, as most mothers prefer that the pediatrician perform childcare on a monthly basis and not nursing. We are more left with the guidelines. (E2)

> I believe that it would be important to have training for health professionals who provide care to premature infants because it is not normal care for a full-term baby and that in the units it is usually the pediatrician who attends, but there may be a need for other professionals to attend. (E4)

A study on the follow-up of premature newborns discharged from the Neonatal ICU showed that care for this population in PHC units often occurs in a fragmented way and is always focused on meeting demand, not meeting what is recommended by the Unified Health System (SUS). The same study shows that, many times, these consultations are restricted to vaccination and growth monitoring, with weighing and measurement of cephalic and length (VIEIRA; MELLO, 2009).

Some authors have already pointed out the need for training nursing professionals for a better qualification in the care of premature newborns, with adequate support for families. They also found weakness in communication between the various professionals and services, resulting in

the fragmentation of care (VIEIRA et al., 2012; ZANI et al., 2014).

It was observed that there is a concern for a more qualified follow-up of premature newborns, but that this does not really happen. It was also identified that some teams work in a multiprofessional way, which is a very important factor for these demands.

> Although it requires greater care due to its fragility, it follows the same care as a full-term newborn. (E6)
>
> Here at the UBS, we have a Team Routine instituted in relation to the PMT service. We provide systematic care, with weekly follow-up if necessary, with a Multiprofessional Team. (E3)

In view of this, PHC was developed to favor the arrival of health services to the community and has important actions of reception and bond-strengthening relationships. Linked to this, the FHS acts as a care model and has a multiprofessional team, being a fundamental tool in the follow-up of premature newborns after hospital discharge, as it comprises unique care and comprehensive care in the planning of health actions (AIRES et al., 2017; SOLANO et al., 2019).

In this way, the FHS proposes that health education be focused on the family, which is assisted and understood as a whole, in its physical and social environment, so that the health-disease process and the need for interventions gain a broader view that goes beyond traditional curative practices (VIEIRA, et al., 2012). For the longitudinal care of premature newborns, the main objective is to maintain periodic consultations and home visits, in order to know the risks and determine the need for intervention early, reducing the chances of new hospitalization (BRASIL, 2012; VIERA et al., 2010).

Comprehensive care based on care and interaction between professionals and family is necessary for the construction of a participatory and efficient therapy. Likewise, the monitoring of these babies should be carried out continuously and early, valuing the bond and dialogue between all parties involved (VIERA; MELLO, 2009).

In this sense, in their study, Aires et al. (2015) report that care for premature newborns is done individually, considering factors such as the needs of each baby, their length of stay in the neonatal ICU, level of severity, development and growth. Every child with a history of low birth weight should be considered at nutritional risk and will need the support and differentiated care of the Primary Care (PHC) health teams, especially in the first year of life, prioritizing healthy growth and development (VIEIRA et al., 2012).

FAMILY AND NEONATAL ICU: COMMUNICATION AND REFERRALS FOR THE FOLLOW-UP OF NEWBORNS IN PRIMARY CARE

This category describes the referrals of the family to primary care and the communication

between the health network. At first, it is observed that the family is instructed by the health agents to go to the unit for postpartum consultations.

> Scheduling carried out by the community health agent and nursing team. (E1)
>
> Family comes on their own, or through scheduling by the ACS. (E2)
>
> The family arrives at the UBS through referral after hospital discharge, or through the active search for the CHAs. (E3)

The community health agent appears as a component in the reorientation of the population and acts according to the health care model, where he discusses his problems with the community, provides support and assists in information (SILVA; DALMASO, 2002). He is a figure of fundamental importance in family health, as he facilitates the needs of the population to reach the health teams and helps in interventions with the community (COSTA et al., 2013).

It is also noted that the family is already informed in some way from the hospital to contact the health unit for the follow-up of the newborn, to make an appointment with a pediatrician when possible, to check vaccines, among other needs.

> After discharge from the ICU, the team itself guides and refers them to the UBS. (E6)
>
> The reference maternity hospital communicates the birth and the team is structured to follow up the follow-up. (E7)
>
> Through a discharge note delivered to the parents when the newborn leaves the neonatal or pediatric ICU. (E9)

There is also a total lack of guidance on returning to the unit after birth:

> There is no referral to the center by the hospital, usually the family arrives at the unit to schedule an appointment to monitor growth and development. (E4)

Regarding the communication between the health network - ICU and basic health unit - the imminent failure in this follow-up is perceived, since five of the interviewees reported that they did not receive any type of contact from the previous hospitalization unit regarding the newborn's permanence in the specialized service.

> There is no communication. (E1)
>
> There is no communication with the Neonatal ICU team. Only exceptions, where the intervention of social assistance is necessary, which makes contact with the ESF to discuss the case and the appropriate referrals. (E2)
>
> Currently, there is no communication with the Neonatal ICU Team. We only received the Discharge Note. (E3)
>
> There is no contact from the hospital stating that there is a premature newborn who will be monitored in the appropriate unit. (E4)

> Usually this reference is flawed. (E7)

The comprehensive care of premature newborns depends on the effectiveness of referral and counter-referral protocols at all levels of health care (JESUS; ASSIS, 2010; BRAZIL, 2012). Without this articulation, "the teams do not know each other, the services do not communicate with each other, and the professionals do not know the reality of the territory in which they work or the result of their actions" (KLOSSOSWSKI et al., 2016).

The country's health service network is still fragile in terms of communication between the levels of care. This impacts on slow, fragmented care, focusing only on diseases and with little bonding, making it difficult to solve the services. The referral and counter-referral process is still deficient and professionals fail to record referrals and the child's own follow-up (AIRES et al., 2017; SOLANO et al., 2019).

The answers also show that communication between these services takes place only by paper, through the hospital discharge note, which is delivered to the team by the family itself in the first consultation with the newborn in the unit. This document is usually marked by medical guidelines to the family regarding the care of the baby and the next steps on the return home.

> Normally, at the time of discharge from the ICU, the family receives all the guidance from the team and sends us the counter-reference document. (E6)

> Discharge note. (E8)

> Through a discharge note delivered to the parents when the newborn leaves the neonatal or pediatric ICU. (E9)

The follow-up of premature newborns requires differentiated care and the hospital and PHC teams must closely monitor this baby. This interaction between professionals favors the exchange of information and continuity in follow-up, meeting the needs of growth and development of premature children (AIRES et al, 2015; BRAZIL, 2014).

CARE FOR PREMATURE NEWBORNS, PERFORMED/ORIENTED IN THEIR PRIMARY CARE AND THE MAIN FACILITIES X DIFFICULTIES

This segment describes the care provided by nursing to premature newborns and its main obstacles. It is perceived that the vast majority of consultations follow a pattern of follow-up between the teams and that sometimes this attention is focused on the medical consultation, as shown in the statements below:

> Growth, development, vaccination schedule. (E1)

> [...] They usually have direct follow-up with a pediatrician in other health units [...]. In the unit, in the consultations, we also guide the care pertinent to the NB, perform anthropometry, etc. [...] (E2)

> Weekly weight. [...] Consultation with a Pediatrician for follow-up of Childcare for 15/15 days (assessing the need for more or less care). [...] (E3)
>
> In the unit where I work, it is the pediatrician who accompanies and as she is a neonatologist, the follow-up is ideal. (E4)
>
> The follow-up would be with the pediatrician of the health unit and with the multidisciplinary team according to the demands presented. (E5)
>
> Care with breastfeeding, vaccines, warning signs, weight, etc. (E6)
>
> Weight and growth monitoring, guidance to parents regarding home care and warning signs. (E7)
>
> Monitoring growth and development is of fundamental importance for promoting children's health and preventing diseases, identifying risk situations and seeking to act early on complications. The care provided to premature newborns in our health unit ranges from weighing, measuring, evaluating thoracic circumference, evaluating head circumference, performing red reflex tests, performing tests such as gait and moro tests for basic neurological evaluation of the newborn to systematic evaluation during their growth and development over time to monitor the acquisition of new skills during the child's growth. We also correctly fill out the child's card, because through the graphs we can see if the child is growing and developing as recommended, in addition to keeping the vaccination calendar up to date as recommended by the National Vaccination Program PNI. (E9)

Aires et al. (2015) highlight some actions carried out by the PHC teams in their study, such as: assessment of neuropsychomotor development and possible sequelae associated with prematurity, assessment of anthropometric measurements using appropriate charts, supplementation and replacement of prescribed vitamins A and D, and prophylaxis with the use of ferrous sulfate. In addition, they comment that a constant concern of professionals is the weight gain of premature newborns, since even after hospital discharge they are still very young babies and that this is the factor of greatest anxiety among caregivers.

The Ministry of Health (2012) recommends that the frequency of consultations with premature newborns will depend on numerous factors and that some determinants - in addition to weight - may result in closer follow-up. It is also necessary to take into account the family environment and the entire PHC network.

It is suggested that three (3) consultations in the first week after hospital discharge, one of which can be carried out at the UBS and the others with the hospital team. That same week, the UBS team should carry out the first home visit to the family. In the second week, two (2) are recommended, preferably one in the hospital and the other in the UBS. From the third week on, one (1) weekly consultation at the UBS or at the hospital of origin (depending on the child's clinical conditions), until the baby reaches 2,500g. After this weight, consultations should follow the guidelines of the Ministry of Health, depending on the child's clinical condition. These consultations should be interspersed with home visits (HV) until twenty-four months. In them, it is also important to review the tests and procedures that were done at the hospital, in order to ensure that all protocols were met (BRASIL, 2017).

In addition, the Ministry of Health advises professionals to be aware of some signs in consultations with premature newborns, especially changes in skin color (cyanosis, marbled skin, intense pallor, jaundice), breathing pauses, respiratory distress, hypoactivity, intense irritation, frequent regurgitation, vomiting, reduction or refusal of breast/diet, and insufficient weight gain or weight loss. In addition to physiological factors, it is always necessary to analyze the family situation, such as signs of well-being or difficulties with the care of the baby, interaction between family members and conditions of the physical environment (BRASIL, 2013).

It is identified that this follow-up, in addition to following a pattern of actions carried out by the teams, home visits stand out as a tool in the care of these babies and their families.

> There are few premature babies who come to the unit. [...] We performed HV and advised the mother about care for premature newborns. [...] PIN visitor also monitors children up to 3 years of age. (E2)
>
> [...] Home visits to monitor breastfeeding and assist/demonstrate the basic care that should be performed by parents with the baby. [...] (E3)

Home visits (HV) are another determinant in the recovery of premature newborns, as they have shown to be an important instrument in family care, allowing them to get closer to users and the environment in which they live (COSTA et al., 2012 and GAIVA; DAYS; SIQUEIRA, 2012). However, care is needed in the way this intervention is carried out, as it can generate negative impressions in the family according to the type of approach used by the professional (VIEIRA; MELLO, 2009).

Nursing professionals believe that home visits are a very important tool in the follow-up of premature newborns. According to them, HV allows for comprehensive monitoring of the family and enables the observation of several other factors, such as hygiene conditions, signs of abuse, among others. This type of intervention also facilitates the creation of a bond with the family and the team (AIRES et al., 2015). Likewise, the active search is a necessary instrument to ensure follow-up in PHC, which ensures the view of care in an integral and singular way about the NB and his family (VIERA; MELLO, 2009). Thus, care for premature newborns in primary care services has been shown to be effective in reducing infant morbidity and mortality and illness in these children (SOUZA et al., 2011).

The interviewees are concerned with maintaining multiprofessional and specialized care, as in the statements below:

> Follow-up of Nutritionist, Speech Therapist, Physiotherapy, SN. (E3)
>
> We initially followed the discharge guidelines and then the guidelines of the pediatrician and the team that performs childcare (nurse, nutritionist, nursing tec). According to the attention to the child, according to notebook N33(MS). (E8)

Finally, in the category that questioned the facilities versus difficulties encountered by the teams in the follow-up of premature babies, several demands were evidenced. Starting with the facilities, the professionals reported that multiprofessional care comes as a fundamental tool and the help of the CHAs is mentioned again. They also highlight the importance of HV to maintain this contact with the unit and family.

> [...] To be able to count on the FHS multiprofessional team, if necessary, in the care of the newborn. [...] (E2)
> The whole team is always very engaged when we have a PMT to follow; and the Community Health Agents always help us. [...]
> (E3)
> [...] Home monitoring by the family health team. (E7)

Aires et al. (2015) explain that the follow-up of premature newborns brings uncertainties and insecurities in professionals, since the care of these children still generates many doubts within the units. There is also a great need for investment in PHC, for a greater scope of the Family Health Strategy (FHS), emphasizing that this model of action favors the creation of bonds and expands the resolution of health problems.

The bond with the family also appears as an instrument that facilitates the management of this population:

> [...] The bond we can create with the family is very important, facilitating interventions through the professionals working in the unit when we need it. (E5)

In addition to all this, the care of a premature newborn requires security on the part of the family members. This safety is only effective with the support of the multidisciplinary team in resolving doubts and guiding care (AIRES et al., 2015). Schmidt (2011) highlights that the family that goes through prematurity depends on the coordination and care of the FHS team to resolve doubts about the ease of adaptation after hospital discharge and for the continuity of therapies with continuous demands. This should all be adapted according to the needs of the NB and the abilities of the caregivers.

Without close contact with the team, however, the family feels insecure to monitor the premature newborn in primary care (AIRES et al., 2015). Families often feel the lack of commitment from the teams in the care of premature newborns, resulting in segmented care based only on established techniques, without looking at the needs of the newborn (VIEIRA; MELLO, 2009).

In his study, Souza (2016) states that nurses are the determining point in communication with families and that they have a very significant role as conflict mediators and emotion mitigators. Souza (2016) also points out that the PHC team is the first contact with the family network and that the bond with PHC professionals is extremely important for the family and for the premature NB,

always aiming at the importance of welcoming, listening and empathy.

> In the difficulties, numerous issues were found that are seen as hindering the care of premature children.
> Lack of pediatric consultation in health units. (E1)
>
> I believe that for units that do not have a pediatrician to monitor premature newborns, it must be very complicated to provide complete care because the monitoring parameters are different and most professionals do not have this training for care, including family doctors. (E4)
>
> Marin et al. (2013) state that regarding the supply of services at different levels and the interaction between them, there is still a disorder between what the population needs and what is offered by the units. This demonstrates that although the creation of the FHS has been a great advance in public health because it contributes to access to the population, the lack of a specialist doctor in some units is still pointed out as a difficulty for care.
> Another difficulty that appears in one of the statements is the lack of adherence to consultations by family members:
> Mothers often do not follow the guidelines, especially in relation to exclusive breastfeeding, non-adherence to childcare consultations by nursing. (E2)
>
> The home management of the family. (E7)

There are numerous factors that influence the failure of exclusive breastfeeding, such as beliefs transmitted by family members, inadequate medical advice, maternal education and age, lack of support from health professionals, among others (TAVEIRO; VIANNA; PANDOLFI, 2020). Often, the user feels dissatisfied in childcare consultations because there is a barrier in communication between the family and the professionals. In order to encourage adherence, nurses must have autonomy and knowledge on the subject, since the protagonist of childcare consultations in the population's view is still the pediatrician. Thus, the nurse needs to stand out in the care, proving to be the holder of the knowledge proposed there (MALAQUIAS; GAÍVA; HIGARASHI, 2015; PEDRAZA; SANTOS, 2017).

A factor that has already been discussed in another category and that now appears as difficulties faced, is the lack of communication between the basic unit and the hospital service:

> We did not receive any feedback from the ICU Team regarding the child. (E3)
>
> One of the interviewees reported difficult access to more specific services in the care of premature babies, when necessary:
>
> The greatest difficulties are in accessing specialized care when the NB needs care that goes beyond Primary Care. (E9)

The third stage of the Kangaroo Method has a great deficiency in primary care, as the policy guides several actions with premature newborns, such as complete physical examination, evaluation of the psychoaffective balance between child and family, correction of risk situations (weight gain, infections and apneas), guiding and monitoring specialized treatments (ophthalmological exams, audiological evaluation and motor physiotherapy), in addition to guidance on immunizations

(KLOSSOSWSKI, et al., 2016).

Monitoring child development, identifying and evaluating risk factors are conditions that can be cared for and require vigilance by specialized teams (MOLINI-AVEJONAS et al., 2018). It is essential to know the reality of care for premature newborns within PHC "from the perspective of professionals and mothers, enabling us to approach this reality and highlight the challenges and overcomings to be undertaken by the team to build comprehensive care for this population" (GAIVA; DAYS; SIQUEIRA, 2012).

The process of child health care is still evolving and, therefore, health professionals need to develop their role based on current public policies that guarantee the quality of health care, promotion and prevention (ARAÚJO et al., 2014). Thus, the training of new health professionals, linked to the new vision of comprehensive care for the user, will influence, in the future, the better applicability of public policies and the implementation of comprehensive and qualified care (KLOSSOSWSKI et al., 2016).

FINAL CONSIDERATIONS

The objective of this study was to know the perception of nursing professionals who work in primary care (PHC) regarding the care of premature newborns discharged from the neonatal unit.

The main results found showed that professionals recognize the importance of comprehensive, specialized and multiprofessional follow-up of premature newborns. The multidisciplinary team is once again an excellent strategy in the follow-up of premature babies. Despite this, there is a need for qualification and training of professionals to fully carry out this development. Home visits are mentioned as a tool that strengthens bonds and helps in childcare consultations, and the figure of the ACS appears as a facilitator of this work.

In general, it was noted that premature babies are still an enigma in primary care and that professionals sometimes feel unprepared for this care. It is perceived that the care - although it occurs in a multiprofessional way, in some cases - is still very centered on the biomedical model, and there should be more incentive in actions to promote the integral health of the child.

In view of the above, it is expected to collaborate to improve nursing actions in the face of care with the follow-up of newborns, stimulating the elaboration of other studies related to the theme.

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