



Parental care of premature children at home: maternal representations

O cuidado paterno ao filho prematuro no ambiente domiciliar: representações maternas

Cuidado de los padres para niños prematuros en casa: representaciones maternas

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ABSTRACT

Objective: to understand the maternal representations in relation to the participation of the parents, who were trained or not through a protocol of care in the neonatal unit, in relation to the care of the premature child in the home environment. **Method:** qualitative research carried out with mothers of premature infants whose companions participated or not in the protocol of child care in the hospital environment. The analysis was carried out through the Collective Subject Discourse. **Results:** twenty-four mothers participated whose companions of 13 performed care and 11 did not. Six central ideas and two anchorages emerged that were grouped into two themes: Fatherly care in the hospital environment and its repercussions on home care; Barriers to fatherly care. **Conclusion and Implications for Practice:** mothers represent paternal participation as positive, especially those whose partners participated in the protocol. However, it was observed that, in some situations, the non-participation was related to cultural influences and/or maternal barriers. In addition, the return to work and paternal fear were barriers to care, regardless of whether or not the father participated in the protocol. The paternal insertion in the care of the premature child in the hospital environment is essential for the improvement of the care for the baby and its family.

Keywords: Premature Infant; Parents; Neonatal Nursing; Child Care; Neonatal Intensive Care Units.

RESUMO

Objetivo: apreender as representações maternas frente à participação dos pais, que foram capacitados ou não por meio de um protocolo de cuidados na unidade neonatal, em relação aos cuidados com o filho prematuro no ambiente domiciliar. **Método:** pesquisa qualitativa realizada com mães de prematuros cujos companheiros participaram ou não do protocolo de cuidados ao filho no ambiente hospitalar. A análise foi realizada por meio do Discurso do Sujeito Coletivo. **Resultados:** participaram 24 mães cujos companheiros de 13 realizaram cuidados e 11 não. Surgiram seis ideias centrais e duas ancoragens que foram agrupadas em dois temas: Cuidado paterno no ambiente hospitalar e suas repercussões no cuidado domiciliar; Barreiras para o cuidado paterno. **Conclusão e Implicações para a Prática:** as mães representam a participação paterna como positiva, principalmente aquelas cujos companheiros participaram do protocolo. Porém, observou-se que, em algumas situações, a não participação paterna estava relacionada com influências culturais e/ou barreiras maternas. Além disso, o retorno ao trabalho e o medo paterno foram barreiras para o cuidado, independentemente da participação ou não do pai no protocolo. A inserção paterna no cuidado ao filho prematuro no ambiente hospitalar é essencial para a melhoria do cuidado ao bebê e sua família.

Palavras-chave: Recém-Nascido Prematuro; Pais; Enfermagem Neonatal; Cuidado da Criança; Unidades de Terapia Intensiva Neonatal.

RESUMEN

Objetivo: comparar las representaciones maternas con respecto a la participación de los padres en el cuidado de niños prematuros en el entorno del hogar, en relación con los padres que participaron o no en un protocolo de cuidado. **Método:** Investigación cualitativa, realizada con madres de bebés prematuros en la que las parejas participaron o no en el protocolo de cuidado del niño en el hospital, de julio a octubre de 2017. El análisis se realizó a través del Discurso del sujeto colectivo. **Resultados:** 24 madres participaron, de estas 13 las parejas brindaron atención y 11 no. Surgieron seis ideas centrales y dos anclas, que se agruparon en dos temas: la atención paterna en el entorno hospitalario y sus repercusiones en la atención domiciliar; y Barreras al cuidado paterno. **Conclusión e Implicaciones para la Práctica:** Las madres que experimentaron la participación de sus parejas en el protocolo de atención representaron este momento con situaciones más satisfactorias en relación con las otras madres. Sin embargo, informaron que regresar al trabajo y el miedo al padre eran barreras para la atención, independientemente de si el padre participó o no en el protocolo. La inserción paterna en el cuidado de niños prematuros en el entorno hospitalario es esencial para mejorar la atención de los bebés prematuros y sus familias.

Palabras clave: Recien Nacido Prematuro; Padres; Enfermería Neonatal; Cuidado del Niño; Unidades de Cuidado Intensivo Neonatal.

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INTRODUCTION

The birth of a premature child can be considered a conflicting moment for the parents and their family, as they experience an extensive and unknown period of hospitalization that occurs in the Neonatal Intensive Care Units (NICU).¹ This hospitalization can generate difficult situations and, consequently, family instability, initiating a phase that is filled with obstacles. Faced with the news regarding the need to stay in the hospital, the family has their dreams and desires of the gestational period undone.²

The insertion of the father in the care of the premature child during hospitalization stimulates the bond between the newborn and the family and contributes to the care of the child at home after discharge.²

It is noticeable that the wishes of the father, and not only the mother, to participate more actively in the care of their child have grown. Men long for their role as fathers, but the experience of hospitalization sometimes does not provide this experience. Although it is the right of fathers to remain with their children all the time in the hospital environment, regardless of the unit, it is noted that the professionals working in neonatal units show some resistance to their inclusion in this environment. The lack of information, interaction, and effective communication with the team, as well as the restriction of the man's permanence in the unit, are factors that limit his participation in exercising fatherhood. Even when the institution allows this access to fathers, it is observed that men are not effectively included in the care of their children. As a result of this situation, many fathers, after their children are discharged, do not feel prepared to take care of them, since they do not believe they are able to replace the trained professionals they met during their child's hospitalization.^{1,3,4}

It is common for parents to go through a reorganization of their lives after the premature discharge of their child, seeking to become capable of caring for him with excellence. However, it is well known that the first days of the child at home are difficult, combined with the physical and emotional fatigue experienced during the period of hospitalization. Some parents feel guilty for not being able to fully cope with the arrival of the baby at home, although they wished for the moment to occur as soon as possible.³

Preparing parents for discharge from hospital requires that they be trained until they feel safe in their caregiving duties. Among them are: touch (skin-to-skin contact, picking up, calming, making the baby sleep); hygiene (perineal, ocular, oral and bathing); breastfeeding (knowledge about milking and breastfeeding assistance); oral administration (medication; bottle for babies who are not being breastfed; offering milk in the cup for babies with prescribed complementation), and knowledge in emergency situations (maneuvers to release and danger signs).⁵ However, it is noticed in most of the services that attend the newborn, that the preparation for the care after hospital discharge is aimed at the mothers.

The participation of the man in the care of the child is important for the father, because it promotes fatherhood, making him more participative, besides providing the strengthening of the bond with the baby, as well as with his partner. In considering

this, a protocol of care directed to the father was developed and implemented to promote the participation of men in the care of premature babies during hospitalization in a neonatal unit of a university hospital in the northern region of Paraná.

Faced with these facts, the following question emerged: "How do mothers perceive the participation of fathers, who have or have not carried out the protocol of care in the neonatal unit, in relation to the care of the premature child in the home environment?". Therefore, this study aimed at capturing the maternal representations in relation to the participation of parents, who were trained or not through a care protocol in the neonatal unit, in relation to the care of the premature child in the home environment.

METHOD

This study consists of a qualitative approach integrated into a large project entitled "The father figure in the care of the premature and low weight newborn in a Neonatal Intensive Care Unit", funded by the National Council for Scientific and Technological Development (CNPq), Process No. 448117/2014-2, whose main goal was to understand and systematize the participation of the father in the care of the premature newborn.

The theoretical framework adopted was the Theory of Social Representation, conceptualized as socially organized knowledge that contributes to the construction of a common reality that stems from the myths and beliefs of society, i.e., common sense.⁶ This framework meets the participants of the study, since it aims to understand the representations created by mothers in the face of parental care. The representations are social because the world is shared among the various people who are a part of it, who support each other, often in a convergent way, other times in a conflicting way, to understand it, manage it or confront it.

This research took place after the approval by the Research Ethics Committee of the State University of Londrina, through CAAE no. 30709814.0.0000.5231, according to Report no. 694.303.

The study site was the Specialty Clinic of the University Hospital (AEHU) of the State University of Londrina. This outpatient clinic performs follow-up consultations to premature infants born at the University Hospital of the State University of Londrina, with a weight of less than 1500g and/or gestational age of less than 34 weeks. There is follow-up done by the resident nurses of the second year of the course of Residence in Neonatal Nursing, along with the team of Neonatal Medicine, until these babies reach one year of corrected age.

Participants in this study were mothers who had children with gestational age below 34 weeks and/or birth weight below 1,500g and who were born between July 2016 and July 2017.

Inclusion criteria were women whose babies had been at home for at least one month and who lived with the child's father. This criterion was necessary in order to have a sense of how the mother experienced the care that the father performed with his premature child in the home. Women whose partners did not accept paternity or in situations where the father did not live with the premature child were excluded from the study.

The protocol is composed of 14 care duties: touching or caressing; picking up; kangarooing; eye hygiene; oral hygiene; changing diapers; bathing; making the baby sleep or calm; breastfeeding awareness; helping with breastfeeding; administering oral medications; administering bottle (for babies who are not being breastfed); offering milk in the cup (for babies with prescribed complementation); knowledge about maneuvers of release, and danger signs.

For the carrying out of this protocol, the parents were guided and trained to carry out the care duties, and the professionals evaluated them during their activities on a scale (performs safely, performs with little insecurity, performs with great insecurity, and performs for the first time). It is worth mentioning that this protocol was validated by a team of Neonatology professionals with experience in clinical care for premature babies. Subsequently, the team was trained for a period of six months and then the protocol was implemented, and has been present in the institution since 2013.⁵ The goal of this protocol was to guide the professionals to include the father during hospitalization in the neonatal unit and, thus, provide greater safety in the care of his child at home.

First, the researcher identified, through the medical team's consultation schedule, which babies were scheduled to be seen at the outpatient clinic during a given week, and interviews were scheduled. Then, a phone call was made to the baby's mother confirming the day of the return appointment. At that time, they were invited to participate in the study and were informed of the objectives, ensuring anonymity and the right to non-participation without any prejudice. The telephone contact with the mothers was made between July and October 2017.

In order to determine the sampling, all newborns who were born between July 2016 and June 2017 and remained in the follow-up clinic from July to October 2017 (n=26) were included. Of these, there were two refusals due to the unwillingness of the mother to attend the early return visit, totaling 24 mothers. The research was stopped after the interviews with all the mothers elected for the study.

The interviews were carried out in the Nursing consultation room, in an individualized manner, without the paternal presence, so that there was no influence in the answers of the mothers and so that they felt more comfortable. In many cases, the babies remained with their fathers in the waiting room, while the mothers were interviewed, since both were present on the day of the consultation and the interview.

The data collection took place after the baby's consultation, lasting approximately 30 minutes, and taking into consideration the initial interaction and the interview itself. The interviews were conducted by four Nursing residents, who were trained in relation to the qualitative research and received theoretical and practical guidance related to the initial approach of the mother and how to conduct the interview, in addition to possible obstacles that could occur during data collection, thus trying to reduce the biases of the research.

The collection period was from July to October 2017 through a semi-structured interview composed of two stages. The first

was the profiling of the mothers (age, schooling, marital status and number of children), and the second was directed to the research objective.

The guiding questions used in the interview to stimulate the mothers' conversation were: 1) Tell me how are the care duties of your child related to domestic activities and work activities distributed? (When carrying out domestic chores, how are the chores and care for the baby distributed? When either one or both of you carry out paid activities, how do you manage the care of the baby?) 2) Who has the greatest bond with the baby and why? and 3) During your child's hospitalization, what care duties were carried out by the father? Talk about it.

However, due to the fact that there are mothers whose companions/partners participated in the protocol or not, there was a need to carry out a specific issue for each group. For the mothers whose partners were participants, another question used was: "Do you believe that the fact that the father performed care (such as bathing, oral hygiene, eye care, etc.) in the NICU had an influence on the care in the home? Tell me about it". And for mothers whose partners did not participate in the care protocol, the question was: "Do you believe that the fact that the father did not have the opportunity to perform care (such as bathing, oral hygiene, eye care, etc.) in the NICU had an influence on home care? Tell me about it".

For the collection, a tape recorder was used so that the interviews could be later transcribed. The transcription was done by the researcher.

The methodological framework adopted for the data analysis was the Collective Subject Discourse (CSD), which allowed the approach with the researched phenomenon. The methodological reference adopted for the data analysis was the Collective Subject Discourse (CSD), which allowed the proximity with the researched phenomenon.

The Collective Subject Discourse (CSD) is a form of statement procedure, i.e., it is a way of grouping, in the form of unique statements, those that have similar meanings in the verbal tense of the first person singular. Discourse syntheses are recreated with fragments of speech, which represent the speech of all subjects.⁷

Four methodological figures were used in this study: key expressions; central idea; anchorage and discourse of the collective subject. Keywords are faithful fragments of the statements that contain the representations of speech. The central idea is the detailed presentation of the meanings present in the discourses. Anchorage is defined as a theory/ideology, that is, an explicit belief in the discourse that is delivered by the individual. The discourse of the collective subject is the grouping of key expressions present in the statements that have central ideas and/or equivalent or complementary anchorages, demonstrating the meaning by all subjects.⁷

After the transcription of the interviews that comprised the pilot test, the researcher read through each speech. Subsequently, feedback was given informing the Nursing residents that the

interviews were adequate, since they met the objective of the study, and no changes to the collection instrument were necessary.

After this stage, the researcher identified and highlighted the key expressions in the same colors as those with similar ideas and the distinct ones in different colors. The coding stage was validated by two researchers external to the study, who have experience in the adopted referential and in the topic studied.

As a result, the central ideas were found and separated based on the key expressions that were identified. Then, the discourse-syntheses were rewritten starting from the excerpts of the mothers' testimonies, with the first person point of view being used so as to represent the opinion of all the participants. The language vices were removed and connectors were used in order to give meaning to the CSD without altering the meaning of the sentence prepared by the participant.

In order to preserve anonymity and facilitate the understanding of the analysis, the acronym "MS" was used for the appointment of mothers whose companions/partners participated in the care protocol, and for those whose companions/partners did not, it was replaced by the acronym "MN", followed by a numerical sequence, respecting the order in which the interviews were conducted.

In order to understand the maternal representations in the different levels of insertion of the fatherly care in the neonatal unit, it was decided to identify the mothers whose partners were or were not trained through a protocol of care for the premature baby.

RESULTS

Twenty-four mothers participated in this survey, 13 of which had companions who participated in the protocol of care focused on the paternal figure during the admission of the premature child and 11 in which their companions did not participate in this protocol.

Regarding the characterization of mothers according to age: 15 to 19 years (8.33%); 20 to 24 years (33.33%); 25 to 29 years (25%); 30 to 34 years (12.5%); 35 to 39 years (16.66%) and 40 to 44 years (4.16%). In terms of schooling level, they were recorded: Incomplete elementary education (12.5%); Complete elementary education (8.33%); Incomplete high school (20.83%); Complete high school (45.83%); Incomplete higher education (4.16%) and Complete higher education (8.33%).

The characterization of babies in relation to the corrected age varied from: zero to three months (54.13%); from four to six months (16.66%); from seven to nine months (12.5%), and ten to 12 months (12.5%). On the other hand, the chronological age varies from: zero to three months (12.5%); from four to six months (41.66%); from seven to nine months (20.83%); from ten to 12 months (16.66%), and 13 months or more (8.33%). The period of stay at home after hospital discharge was: zero to three months (50%); four to six months (16.66%); seven to nine months (12.5%) and ten to 12 months (20.83%). Despite the great difference in age of newborns, this was a positive factor, since they are premature children, the first year of life demands a greater burden of care. Moreover, this time period makes it possible to understand the variations of the inclusion of the father in the care.

As for the characterization of the companions of women who participated in the survey according to age, they were: 20 to 24 years (29.16%); 25 to 29 years (20.83%); 30 to 34 years (16.66%); 35 to 39 years (25%); 40 to 44 years (4.16%), and 45 years or older (4.16%). In relation to their level of schooling, they were: Incomplete elementary education (25%); Complete elementary education (12.5%); Incomplete high school (16.66%); Complete high school (12.5%); Incomplete higher education (12.5%), and Complete higher education (20.83%).

In relation to the marital situation, 58.33% are married and 45.83% live in a stable union. In relation to the number of children, for most of the mothers, this baby is the first child (62.50%) and 29.16% and 8.33%, respectively, have two and three children.

From the empirical material analysis, six Central Ideas (CI) and two Anchorages (Ac) emerged, which were organized in two themes: 1) Paternal care in the hospital environment and its repercussions on home care (CI1 - Share of care with companion; CI2 - Valuing the father's involvement in care) and 2) Barriers to paternal care (CI3 - Lack of paternal initiative and maternal insecurity for care; CI4 - Fear leading to paternal absence; CI5 - Work and paternal fear interfering in the care; CI6 - Cultural influence; Ac1 - He thinks a girl has to be cared for by her mother; Ac2 - Father can't care or change "daughter-wife").

Theme 1 - Paternal care in the hospital environment and its repercussions on home care

Mothers report that their partners help with child care at home. In the speeches below, it can be observed that the parents participating in the protocol perform various cares, either in the care of the child or helping in domestic tasks. And for men who have not been cared for during hospitalization, the help to the partner occurs more at specific times, such as at night or at the end of the week.

CI1 – Division of care with the partner

CSD1: *He helps me in the exchanges; when she is colicky, he takes her lap, helps in the bath, exchanges, bottle feeds, puts to sleep, we always give a bath together. At home services, he usually makes food, does the dishes and cleans the house to help me. We share everything. One day one wakes up at dawn, the next day the other wakes up (MS1, MS3, MS4, MS9, MS10, MS13).*

CSD2: *Whoever is less busy goes there and does it, but, generally, bathing and changing is me who does it. In domestic services, it's up to me too. He watches the baby for me while I have dinner (MN8, MN9).*

CSD3: *During the day, it's more me who takes care of, although there are days when we review a little. When he comes from the service, he helps. He bottle feeds her, he changes her diaper, helps in the bath and puts our daughter to sleep. Then, at night, he wakes up to feed her and pick her up; at the weekend, he helps me more.*

He helps me at home too, cleans and washes the dishes (MS2, MS6, MS8, MS11, MS12).

CSD4: *When my husband comes home from work, he helps me. Sometimes he changes our son, feed him, but it is rare - in fact, he plays with him while I clean the house. Because of work, he helps me more on weekends and at night (MN1, MN3, MN4, MN6, MN11).*

Another positive point observed in the maternal representations was the valorization attributed to the partner in relation to the activities that were carried out in the hospital environment with the premature child. Even in relation to the parents who could not participate in the care present in the protocol, some mothers mentioned that they assisted in the care in an equal way with those who participated, as identified in the following speeches.

CI2 - Appreciating the participation of the father in care

CSD5: *During the hospitalization, he changed diapers, gave a bath - he who gave the first bath -, did a kangaroo, changed diapers, gave milk to him in the "sippy cup", gave medication in the "little spoon". At night, he went at feeding time and I did not go at any time of the night. He cleaned the "little eyes", the "little mouth". Even more, the "little eyes" and the "little mouth" business; he did it first. Until today, he cleans and does everything he learned at the hospital, besides that he was all happy to be participating. Every time we went back to the hospital it was an uncertainty: "Wow, will she survive? So, being able to participate in this was very rewarding. He even cleaned the incubator (MS1-MS12).*

CSD6: *During hospitalization, he did a lot of kangarooing. He once had changed diapers and cleaned his mouth. He was very scared and the nurse insisted a lot for him to do it (MN4, MN8-MN11).*

However, mothers recognize that the fact that the partner had the possibility of care in the hospital environment was a facilitator for home care, enabling him to carry out various cares with the child.

CSD7: *Being able to take care of it at the hospital had a lot of influence at home because we lost a little of the fear of handling her; in the beginning, we were even afraid to touch her. When I got pregnant, people told him that he would have to change diapers and he said that he did not want to change diapers. Now he changes. He was afraid because she was too "little". He was afraid in the first days, so he wouldn't change, he wouldn't bathe because he was very afraid. Then, only after a while he started to do the bathing and changing. The first time he could catch it he made kangaroo, but, in the beginning, he was very afraid. He said he was afraid to "break", that he was very*

little, but little by little, always taking care at the hospital, he was losing his fear and now, at home, he has no fear (MS1, MS4, MS10-MS12).

CSD8: *I find him very careful. Sometimes he is even more careful than me. I think because he accompanied our son in the ICU, today, at home, he knows how to do much more things; he knows how to take care, but before, he didn't know, he learned everything there. I found it easier because the mother talking is one thing, the nurse talking is another (MS2, MS5, MS6, MS8, MS9, MS13).*

Mothers referred, in a positive way, to the insertion of the father in the care of their child, because it made it possible to compare the way of caring they experienced in the birth of older children and the care made possible in this birth, emphasizing that the insertion of the father in the care allowed him to become more participatory and to experience, in a fuller way, his fatherhood.

CSD9: *My husband already knew how to take care of children because he already has other children from another relationship and always helped to take care of the children, but having the opportunity to take care at the hospital helped a lot - he usually says that he did not 'like' the other children as much as he is enjoying this one. This is because when he had the first ones, he couldn't take care of them, he wasn't inserted and wasn't trained to take care of them. Now, when I have to take our son to the doctor, he wants to go to the consultation, to know what his son has, how is his health; he is the one who likes to talk about everything that is happening with our son. He is very participative (MS3, MS7).*

On the other hand, negative representations were mentioned by the mothers of the study in view of the lack of initiative of the partner to take care of the baby, especially in situations where he did not participate in the care of the premature child in the hospital environment, as observed in CSD10 and 11.

Theme 2 - Barriers to paternal care

CI3 – Lack of paternal initiative and maternal insecurity in care

CSD10: *So, actually, since Dad works away from home, I'll stay with her. And, generally, it's more me who performs all the care. At night, when he comes home, sometimes I ask: "Ah, love, change her diaper" or feed her, "prepare the bottle" (MN6, MN8).*

CSD11: *His father doesn't take much care of him, because I'm the one who stays the longest with our son. My husband is very quiet, very "detached" for the care; I have to keep talking and sometimes I ask: "You need to change him, go and change". Because, if it depends on*

him, it's all right. In fact, I prefer to take care of it myself, because I'm a little afraid to let my husband take care of it. (MN2, MN5, MN9, MN10).

Some mothers perceive, in a negative way, that the absence and non-participation of the father in the care of the child during hospitalization, justified by the paternal fear of caring, had, as a consequence, less interaction with the child today at home.

CI4 – Fear leading to paternal absence

CSD12: *I think that if my husband was more present when our son was hospitalized, he would have more affection for him. My husband doesn't know anything about our son, he doesn't know all the things that our baby went through in the hospital - when he went, he stayed for a short time and soon left. He wouldn't stay directly at the hospital, that I remember. It was at home that he changed his diaper, but it was only once until now. Bathing, he doesn't give because he says that the baby is very 'soft' and is afraid, getting a little afraid. So much so that, sometimes, I need to leave our son with him to leave home quickly and he already speaks: "No, I'm not staying here alone with him". He's scared to death, he won't stay with the baby alone in the house. Only I have to be alone with our baby. If, suddenly, the baby takes a different breath, he already calls me. I think if he had participated in the care at the hospital, he would have lost his fear and would have been able to help me at home. (MN4, MN5).*

However, other factors independent of the father's desire were difficult for the father's participation, even for those who took care in the hospital, because they needed to make adjustments in their routine. The need to return to work, associated to the fear of taking care of the premature baby, made its presence and participation in the care of the premature child in the hospital environment difficult, as reported in CSD13, 14 and 15.

CI5 - Work and paternal fear interfering with care

CSD13: *He went every day after work. As I remember, what he did most at the hospital was change his diaper and kangaroo, but he was afraid because it was too "little". The bath was offered, but he refused because she was "tiny". He got scared, nervous and desperate; only after almost a month that he had courage and gave a bath (MS9, MS13).*

CSD14: *My husband can't take care at the hospital because of work and because he was afraid, but I think this didn't interfere, because here at home he helps me whenever he can. If he is at home, he bathes, changes diapers, he does everything. For example, when we have an appointment here [in the outpatient clinic], in the men's room there's no diaper and I was making an appointment*

and the baby needed to be changed; my husband went into the ladies' room, locked the door and changed him for me (MN1, MN3, MN8).

CSD15: *At first he went every day, then no, because he was working. And it was a day yes and a day no. With this, he ended up spending little time and soon he had to go back to work, so I was the one who stayed the longest with our son at the hospital. My husband did not take much care, it was more this part of changing, which then, when she was already in the ICU, he did little because he had to go back to work (MN1-MN6).*

However, there are other factors that may interfere with the father's participation. In the case of non-participating fathers, these are cultural factors, such as the stigma that the man should not care for his daughter because he is of the opposite sex or that the father's role should be that of provider and not caregiver. Thus, there is the conception that the attribution of caring should be delegated to the maternal figure, which was present in the CSD16.

CI6 – Cultural Influence

Two anchorages have emerged, although both point out that female children should be cared for by their mother. In the first anchorage, this is a paternal vision and the second anchorage is related to the maternal precepts.

Ac 1 – He thinks a girl has to be taken care of by her mother

CSD16: *My husband is sexist: "Girls have to be taken care of by their mother". If it was a boy, he would help a little bit more. And he also said that he will only feed her when she gets older, because now he is afraid. As I say, in his head, "girl-woman", the man can't be touching her intimate parts, but we have another son, a boy, and he never changed him either. That's because he is disgusted, he said: "He'll die if he has poop in his diaper. I think it's because my husband didn't have any encouragement, he was a little withdrawn, he didn't have any opportunities, he had a suffering life. But, so, regarding dedication, if he could, he would take the sky and give it to our daughter - not only to her, but to me too (MN7, MN9).*

Ac 2 - Father cannot care for or change "daughter-woman"

CSD17: *In house chores, he helps me a lot, I just have to thank him. And also for being a "daughter-girl", I don't insist that the father has to clean. I don't know, I don't think it's right, but my mother [baby's maternal grandmother] always says that the father can't take care of or change*

“daughter-girl”, so I keep it in my head. I like to take care of her myself (MN6, MN10).

However, it was observed that it is often the women themselves who limit the participation of the father in child care, both those who have participated and those who have not, as represented in CSD17 and 18.

CSD18: *I stay the whole time, I don't let anybody take the child. My sister came here to see her these days and told me to stop being a pain, let her and her family take care of her, pick her up a little bit, but I won't let them. I think it's because of feeding too. Sleeping, she doesn't sleep with her father at all; in her father's lap, she doesn't sleep, it's just with me (MS1, MS3-MS5, MS8-MS12).*

CSD19: *I think she (baby) needs her mother more in this moment here at home, because I am more present, I am the one who takes care and feeds her. Sometimes she stays with her father and soon she starts to cry, then I pick her up because she wants me, her mother, and I realize that when I pick her up, she stops crying - it's automatic. I think this happens because of the time I stayed with her, the 23 days of the ICU following... I had more presence, I think she got used to it (MN1, MN4-MN6, MN8-MN11).*

DISCUSSION

The results revealed that some mothers whose companions participated in the protocol in the hospital environment noticed a greater involvement of the father with the care of his child. Some mothers whose partners were not present and did not participate in this care, cultural aspects, the return to work and fear were represented as barriers to early child care in the home environment.

It is known that the father and mother have different representations regarding the birth, bond and care of the baby, as emphasized in a study conducted with fathers and mothers of babies admitted to a NICU in Norway. The research showed that, for mothers, the birth of a child prematurely generates the feeling of impotence, while, for the father, it is something strange and unreal. After discharge, the mother seeks to strengthen the bond with her son, who was harmed due to hospitalization, while the father seeks to develop this bond.⁸ This shows the importance of stimulating man's participation in baby care, aiming at the creation of the father-son bond early on.

Mothers represented their partner's participation in child care, highlighting that this fact enabled greater support for them in times of stress and uncertainty and helped the father in his empowerment to care for his child.

A study conducted with neonatal unit parents showed that the man who has the possibility of being inserted in the care acquires dexterity and security with the same intensity as the mother and, in this way, facilitates the care of the father with the premature

son in the home. Therefore, the paternal participation is seen as positive and beneficial, because it provides confidence and widens the man's knowledge about the baby's history, even for families that already have other children. It also helps to reduce fear, which has been cited as an important limiting factor in the father's care.⁹

However, it is noticeable in the representations of some mothers, whose partners did not participate in the care protocol, that this has become a barrier to strengthening the bond between father and son and minimizing fatherly fear for greater participation in the life of the child after hospital discharge. This observation corroborates a study that followed, over a period of ten years, fathers and mothers of premature newborns, which identified that many fathers do not trust themselves to take care of the baby at home, do not feel “good fathers” and presented a high level of stress and that these negative aspects could have been minimized by the support of the health team through their insertion in the care of the child during the period of hospitalization.⁴

It is worth mentioning that some mothers referred to negative representations in relation to the partner in relation to care, emphasizing that they only performed some activity if requested. However, it is important to emphasize that some women believe in concepts dictated for a long time by society in relation to the roles that the father and mother should exercise in the family, being the father the provider and the mother the caregiver, regardless of the father's desire to participate in the care.

This fact is reinforced in a study carried out with fathers and mothers on how fatherhood and motherhood develop in the first six months of life, pointing out that it is women who assume the integral care of babies, which causes them great satisfaction in carrying it out. The father acts as a secondary caregiver with a role of zeal, sustenance, assistance, help and support. In this way, he acts when there is no presence of the woman and when it is necessary.¹⁰ This reinforces the cultural stigma that it is the woman who must stay at home and take care of children while the man goes out to work and is the provider.^{10,11}

Another aspect pointed out by mothers as a barrier for the father to take care of his child is related to the demands of work and the fear of taking care. The long working hours of the fathers make them have little free time to stay with the baby, and often the father chooses to increase his workload due to the concern in providing for the house with the arrival of the son.¹²

It is known that, in Brazil, the paternity leave corresponds to only five days, which begin to be counted right after the birth of the baby. Thus, this is an obstacle for the father to experience his fatherhood and help the mother, especially in cases of premature birth and need for long periods of hospitalization.¹³

A survey of fathers whose premature children were admitted to the NICU of a maternity ward in Rio de Janeiro showed that men identified the premature as an immature, small, and fragile being, so they are afraid to take care of their child. This leads to an estrangement from the father in relation to the baby, therefore, it is important to foster this care, thus enabling the promotion of the father-baby bond. As a result, men are becoming accustomed

to the physical characteristics of their premature babies and are identifying themselves as fathers.¹⁴ As a justification for the father's absence from care, mothers perceive fear in the face of the frailties of a premature baby.

Other factors were limiting to the insertion of the father in the care, such as the maternal non-belief that the partner may be able to meet the demands of the child. Many times, it is the woman who limits the father's participation by not trusting her partner to take care of the baby, feels jealous and believes that, because she is the mother, she is the one who should be solely responsible for the care^{10,11}

In a survey carried out with women regarding their perception of their father's role, it was noticed that, as in this study, the woman expects her partner to be the provider of the home and she, the caregiver.¹¹ Facing this context, it is necessary the development of strategies that favor the mother's understanding of the father's role in the care, since the man's participation in the baby care enables the baby's emotional, affective and social development through the child's upbringing and the realization of simple cares, such as a diaper change. When the woman allows the man to participate in the care, she stimulates the relationship of the father with the baby and there are fewer burdens for her since she has a partner to share the care. Often the mother's desire is for the man to be a partner, a source of support and affection and not necessarily a partner for sharing household chores and baby care.¹¹

It is known that when the father is participatory, there are better social skills, greater empathy, and emotional control, besides acting on the motor, cognitive and social development of the baby, also collaborating for the construction of a safe attachment. In other words, the participation of the father in the care of the child in the first years of life is important both for the paternity and for the development of the baby.¹⁵

The basic cares, such as bath, hygiene, food, among others, are related to the mother, while the parents are assigned the care as leisure, games and calming the child, besides being providers of the children.¹⁵ However, some mothers are not satisfied with being responsible for baby care, expressing feelings of dissatisfaction with paternal participation and a desire for greater father involvement, although these findings are more frequent in women who are economically active.¹²

The man should be treated as an active and participatory member in the care of the baby for the development of his fatherhood, improvement of family welfare and relations between family members, which should begin from gestation. Orientations and conducts for a safe discharge of the premature baby should be directed to the father and mother and not only to the woman.¹¹

It is important to point out that the social representations in relation to the genders were an obstacle to paternal care, since some mothers mentioned that the father could not offer the care because his son belonged to the female sex, and this context is also focused by some relatives, such as grandparents. In some communities, there is still a common sense that "father should take care of son-man" and "mother should take care of daughter-wife. In this study, it was possible to identify two anchors of this theme.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

This study provided the apprehension of the maternal representations in relation to the home care carried out by the partners. Some mothers represented the presence of fathers in hospital care in a positive way, referring to satisfaction and appreciation of the father's role as caregiver and supporter. In addition, they realized that their companions felt safer, more capable and participative in home care.

On the other hand, some mothers represented negative aspects of the father's non-participation in the care in the hospital environment, mentioning that if the father had taken care during the baby's hospitalization, he would be more participative, understandable and wouldn't be so afraid to take care of the child at home. It is important to point out that these negative aspects can be related to cultural stigma in which the woman should be responsible for the direct care of the baby and the father the provider of the house, thus making it difficult for the father to be inserted in this process.

It was observed that some parents not participating in the care protocol did not and still do not carry out the care not only because their don't want to, but because of maternal barriers in which the mother does not believe that her partner is capable of caring for her child or because of cultural influences, in view of believing that, because the partner is male, he should provide the sustenance and not the care for the child.

Other relevant points, which were identified as a barrier to paternal care, were the demands of work and the fear involved in the care that had, as a consequence, less time spent by the father with the child in the hospital environment, which also persisted at home.

It is necessary for men to be increasingly inserted in the care of their children and, for this, it is necessary that health professionals value the father figure in the care process and, in this way, spread this idea throughout the family. It is necessary to give voice to the new father that appears in society, that is, a father who is more participatory in the care of his children, who wants to demonstrate his affections, fears and support.

This study made it possible to reflect on the importance of paternal insertion in the care of the premature child in the hospital environment, in order to be essential for the improvement of the care of the premature child and their family. Thus, it was possible to realize the importance of neonatal nursing in embracing fathers and mothers during the baby's hospitalization, empowering them and inserting them more and more in the care of their children. Moreover, this team needs to be trained, since the perception about its importance provides less judgment and, consequently, a closer relationship between professionals and the fathers and mothers of these babies. In this way, a better environment emerges for the realization of a quality and humanized assistance to the premature child and their family.

As an implication for the practice, the following arguments are raised: the health professional can rely on guidelines that strengthen family-centered care, as well as identify how family

relationships occur and thus support them, respecting their beliefs and cultures, as well as provide that they can experience and/or develop their motherhood and fatherhood.

The limitations of this study are related to the fact that, although all parents had premature children and the family-centered care often occurs through various care strategies of this unit, especially with the use of the paternal care protocol, the results found were of only one scenario. In this sense, it is recommended that new studies be carried out in other scenarios to understand the maternal representations of premature babies before the participation or not of the father in the care of the premature child, or even that another theoretical and methodological reference be used in order to contribute to the care practice of Neonatal Nursing.

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REFERENCES

1. Petty J, Whiting L, Green J, Fowler C. Parents' views on preparation to care for extremely premature infants at home. *Nurs Child Young People*. 2018;30(5):22-7. <http://dx.doi.org/10.7748/ncyp.2018.e1084>. PMID:29975481.
2. Veronez, M. Vivência de mães de bebês prematuros do nascimento a alta: notas de diários de campo. *Rev. Gaúcha Enferm*. 2017;38(2):e60911. <http://dx.doi.org/10.1590/1983-1447.2017.02.60911>.
3. Marski BSL, Custodio N, Abreu FCP, Melo DF, Wernet M. Alta hospitalar do recém-nascido prematuro: experiência do pai. *Rev Bras Enferm*. 2016 abr;69(2):221-8. <http://dx.doi.org/10.1590/0034-7167.2016690203i>. PMID:27280556.
4. Boykova M. Life after discharge: what parents of preterm infants say about their transition to home. *Newborn Infant Nurs Rev*. 2016;16(1):58-65. <http://dx.doi.org/10.1053/j.nainr.2016.03.002>.
5. Silva TRS, Silva VCE, Parada CMGL, Zani AV. Validação de um instrumento de cuidados ao prematuro voltado a figura paterna. *Rev Eletrônica Acervo Saúde*. 2018;10(3):1641-7. http://dx.doi.org/10.25248/REAS210_2018.
6. Jodelet D. O movimento de retorno ao sujeito e a abordagem das representações sociais. *Soc Estado*. 2009;24(3):679-712. <http://dx.doi.org/10.1590/S0102-69922009000300004>.
7. Lefèvre F; Lefèvre, AMC, Marques, MCC. Discurso do sujeito coletivo, complexidade e auto-organização. *Ciênc. saúde coletiva*. 2009;4(1):1193-204. <http://dx.doi.org/10.1590/S1413-81232009000400025>.
8. Provenzi L, Barello S, Fumagalli M, Graffigna G, Sirgiovanni I, Savarese M et al. A comparison of maternal and paternal experiences of becoming parents of a very preterm infant. *J Obstet Gynecol Neonatal Nurs*. 2016;45(4):528-41. <http://dx.doi.org/10.1016/j.jogn.2016.04.004>. PMID:27266963.
9. Santana JO, Borges KI, Souza DA, Pinto KRTF, Rossetto EG, Zani AV. Paternal care for hospitalized premature children: maternal representations. *Rev baiana enferm*. 2017;31(4):1-8. <http://dx.doi.org/10.18471/rbe.v31i4.22310>.
10. Martins C, Abreu W, Figueiredo M. Tornar-se pai e mãe: um papel socialmente construído. *Revista de Enfermagem Referência*. 2014 jun 30;IV Série(2):121-31. <http://dx.doi.org/10.12707/RIII1394>.
11. Dessen MA, Oliveira MR. Envolvimento paterno durante o nascimento dos filhos: pai "real" e "ideal" na perspectiva materna. *Psicol Reflex Crit*. 2013;26(1):184-92. <http://dx.doi.org/10.1590/S0102-79722013000100020>.
12. Castoldi L, Gonçalves TR, Lopes RCS. Envolvimento paterno da gestação ao primeiro ano de vida do bebê. *Psicol Estud*. 2014;19(2):247-59. <http://dx.doi.org/10.1590/1413-737222105008>.
13. Constituição de 1988 (BR). Constituição da República Federativa do Brasil. Diário Oficial da União [periódico na internet], Brasília (DF), 5 abr 1988 [citado 2018 jun 15]. Disponível em: <http://www2.camara.leg.br/legin/fed/consti/1988/constituicao-1988-5-outubro-1988-322142-publicacaooriginal-1-pl.html>
14. Soares RLSF, Christoffel MM, Rodrigues EC, Machado MED, Cunha AL. Being a father of a premature newborn at neonatal intensive care unit: from parenthood to fatherhood. *Esc Anna Nery*. 2015;19(3):409-16. <http://dx.doi.org/10.5935/1414-8145.20150054>.
15. Gabriel MR, Polli RG, Dall'Agnol LF, Tudge J, Piccinini CA. Envolvimento paterno aos 24 meses de vida da criança. *Psicol.: Teor e Pesqui*. 2017;33(1):1-10. <http://dx.doi.org/10.1590/0102.3772e33410>.