CARE FOR PRETERM CHILD IN HOUSE: FATHERLY EXPERIENCES

Carolina Mathiolli[1]

Cristina Maria Garcia de Lima Parada[2]

Rosangela Aparecida Pimenta Ferrari[1]

Adriana Valongo Zani[1]

[1]Universidade Estadual de Londrina, Programa de Pós-Graduação em Enfermagem. Londrina, Paraná, Brasil.

[2]Universidade Estadual Paulista, Faculdade de Medicina de Botucatu, Programa de Pós-Graduação em Enfermagem. Botucatu, São Paulo, Brasil.

ABSTRACT

Objective: to apprehend the paternal experiences related to the care provided to the preterm child at home by comparing the parents participating or not in the care protocol.
Method: a qualitative research, conducted from July to October 2017, with 24 parents of preterm infants after discharge from a teaching hospital in the state of Paraná, Brazil, who participated or not in a care protocol during the period of hospitalization. The analysis was performed through the Collective Subject Discourse.
Results: the parents who had the opportunity to participate in the protocol at the hospital reported that this care was important so that they could help their partners with their children at home. However, the parents participating or not in the protocol realize that the mother has a greater bond because of the possibility of greater time availability and because they are the nursing mothers and refer to work as a barrier to child care.
Conclusion: the parents participating in the protocol report that it had a positive impact on their child care at home, in contrast, non-participating parents reported that having been included or not in the protocol did not interfere with their conduct at home. However, both groups agree that cultural factors and work are barriers to child care.

DESCRIPTORS: Preterm newborn. Parents. Neonatal nursing. Child care. Neonatal intensive care units.

HOW CITED: Mathiolli C, Parada CMGL, Ferrari, RAP, Zani AV. Care for preterm child in house: fatherly experiences. Texto Contexto Enferm [Internet]. 2020 [cited YEAR MONTH DAY]; 29: e20190033. Available from: https://doi.org/10.1590/1980-265X-TCE-2019-0033

CUIDADO AO FILHO PRÉ-TERMO NO DOMICÍLIO: VIVÊNCIAS PATERNAS

RESUMO

Objetivo: apreender as vivências paternas referente aos cuidados prestados ao filho pré-termo no domicílio comparando os pais participantes ou não do protocolo de cuidados.
Método: pesquisa qualitativa, realizada no período de julho a outubro de 2017, com 24 pais de bebês pré-termos após a alta hospitalar de um hospital escola do estado Paraná, Brasil. Os quais participaram ou não de um protocolo de cuidados durante o período de internação. A análise foi realizada por meio do Discurso do Sujeito Coletivo.
Resultados: os pais que tiveram oportunidade de participar do protocolo no hospital referiram que estes cuidados foram importantes para que pudessem ajudar suas companheiras com seus filhos no domicílio. Contudo, os pais participantes ou não do protocolo percebem que a mãe possui maior vinculo devido à possibilidade de maior disponibilidade de tempo e por serem as nutrizes dos filhos e referem o trabalho como uma barreira para o cuidado com o filho.
Conclusão: os pais participantes do protocolo referem que o mesmo repercutiu positivamente nos cuidados com o filho no domicilio, em contrapartida os pais não participantes referem que terem ou não realizado o protocolo não interferiu em suas condutas no domicilio, no entanto, ambos concordam que fatores culturais e o trabalho são barreiras para o cuidado ao filho.

DESCRITORES: Recém-nascido pré-termo. Pais. Enfermagem Neonatal. Cuidado da criança. Unidades de terapia intensiva neonatal.

CUIDADOS AL HIJO PRETÉRMINO EN EL DOMICILIO: EXPERIENCIAS PATERNAS

RESUMEN

Objetivo: conocer acerca de la experiencia de los padres en los cuidados prestados a hijos prematuros en el domicilio, comparando a padres que participaron en el protocolo de cuidados con aquellos que no participaron del mismo.
Método: investigación cualitativa, realizada entre julio y octubre de 2017, con 24 padres de bebés prematuros después del alta hospitalar, en un hospital escuela del Estado de Paraná, Brasil, con padres que hubiesen o no participado en el protocolo de cuidados durante el período de internación. El análisis se realizó por medio del Discurso del Sujeto Colectivo.
Resultados: los padres que tuvieron la oportunidad del participar en el protocolo en el hospital, advirtieron que esos cuidados fueron importantes a los efectos de poder ayudar a sus compañeras en el domicilio. Sin embargo, tanto los padres que habían participado del protocolo como aquellos que no lo habían hecho, coinciden en que la madre posee um vínculo más intenso debido a la posibilidad de disponer de más tiempo y al hecho de ser ellas quienes alimentan a sus hijos, reconociendo que el trabajo opera como barrera en lo que respecta al cuidado de su hijo.
Conclusión: los padres que participaron en el protocolo refieren que el mismo repercutió favorablemente en los cuidados con el hijo en el domicilio. En contrapartida, los padres que no participaron refirieron que el hecho de haber participado o no en el protocolo, no incidió en su conducta en el domicilio. Por otra parte, los dos grupos concuerdan en que los factores culturales y el trabajo operan como barreras en el cuidado a sus hijos.

DESCRIPTORES: Recién nacido prematuro. Padres. Enfermería neonatal. Cuidado del niño. Unidades de terapia intensiva neonatal.

INTRODUCTION

Over the last decades, man has been seeking new spaces in front of his fatherhood. The "patriarchal model", in which men were exclusively responsible for providing the house and women as caregivers and educators of children, has been changing over time. With this, various family models are emerging in postmodern society.[1]

Due to this context of man's greatest desire to become a father and be inserted in the child's life, policies have been developed and implemented to enable such insertion. In Brazil, the Ministry of Health implemented the National Policy for Integral Attention to Men's Health in 2008, which has among its objectives responsible parenthood through the participation and inclusion of men in sexual and reproductive planning. In Rio de Janeiro, the Paternity Appreciation Movement was set up to promote initiatives that encourage the inclusion of men in child rearing. Because of this, August was chosen as the "Paternity Appreciation Month", in which organizations, health units and schools carry out paternity-promoting activitie.[2]

Fatherhood includes intense transformations in man's life that begin during the gestational period, with the inclusion of new responsibilities and roles, as well as the establishment of the father-baby relationship.[1]

When the child is born preterm, there is a change in all the planning that was performed during the gestational period. The man experiences a period of frustration, because it is an unexpected event, generating feelings of suffering, fear, anguish, worry, guilt and helplessness in the face of the child's gravity, besides the desire to take him/her home. These feelings occur because fathers/men are not psychologically, emotionally and physically prepared to cope with the child' preterm birth, as well as the care process. It is noteworthy that in this new context, the development of parenting may not occur as desired, leading to an emotional imbalance of men, causing anxiety, stress, isolation, sadness and even separation from their partners.[3–4]

Despite the difficulties faced, man has been realizing his importance in the participation of child care and paternity has been increasingly promoted by health policies. Thus, a paternal care protocol was developed and implemented to stimulate the father's participation in the care of the preterm child in the Neonatal Therapy Care Unit (NITU) and the Neonatal Intermediate Care Unit (NICU) of the University Hospital of Londrina (HUL). However, it is recognized that the inclusion and performance of man in preterm baby care should transcend the hospital environment. Yet, it is observed that the participation of the father/man in the care of the child in the home environment is a moment that requires adjustments, brings insecurities and imposes decision-making about child care, however the father/man has being disregarded, because their participation in the gestational process and in the NICU was restricted and the maternal behavior is to take full care of the child.[5] In this sense, because most studies explore the maternal perspective the objective of this research was to apprehend the paternal experiences regarding the care provided to preterm child at home comparing parents participating or not in the care protocol.

METHOD

This is a qualitative study, based on the theoretical framework of Social Representations, which has great adherence to the study objects of health field, since it can comprehend the most subjective aspects that permeate the problems inherent in this area. Social Representations are a series of opinions, explanations and statements produced based on the daily life of groups, and communication is the primary element in this process.[6]

At first, a care protocol focused on the father was developed, which comprises 14 care measures[7] (touched and/or caressed; hold the baby; made kangaroo; eye hygiene; oral hygiene; diaper change; bath; made the baby sleep or calm down; knowledge of milking; assisted the mother during breastfeeding; administered oral medications; administered a bottle to non-breastfed babies; offered milk in the glass (in cases of prescription of complement), knowledge about the care maneuvers and signs of danger), in which the father is able to use it with his hospitalized preterm child. For this there are four levels of safety for evaluation by the professional who accompanied the man in performing this care, which are: Father runs safely; Father carries out the care with some insecurity; Father performs care with great insecurity; Father is performing the care for the first time.

This protocol has been validated by neonatology professionals with extensive experience in clinical care of preterm newborns. After validation, presentation and training of the protocol to the multi-professional team working in the neonatology service of the study institution, it was implemented and has been inserted in the service since 2013.

The care protocol was offered to all parents of preterm babies who were admitted to the University Hospital Neonatal Unit, which is a reference for high-risk pregnancies and preterm births. The Neonatal Unit has a capacity of 10 beds of Neonatal Intensive Therapy Unit (NITU), 10 beds of Intermediate Care Unit (ICU) and four beds of Kangaroo Unit. Although the protocol was offered to all fathers, not everyone was available to stay in the unit during the period of hospitalization because of return to work and/or having to take care of other children and domestic activities, thus helping their partners to stay longer with their children in the hospital unit.

Data collection was performed at the preterm follow-up outpatient clinic of the University Hospital Specialist Outpatient Clinic (*Ambulatório de Especialidades do Hospital Universitário*, AEHU) belonging to the State University of Londrina. The institution, field of study, has follow-up care for preterm infants born at the University Hospital weighing less than 1,500g or gestational age less than 34 weeks. In this outpatient clinic, residents of the second year of Neonatal Nursing follow up on these preterm babies with the neonatal medicine team until they are one year of corrected age.

Participated in this study fathers who had children with gestational age less than 34 weeks and/or birth weight less than 1,500g who were born between July 2016 and July 2017.

The inclusion criteria were the following: fathers, over 18 years old, who lived in the same household with their children, and had daily contact with them, whether or not they participated in the protocol of care with their preterm child, whose children were already at least one month at home. This criterion was necessary so that one could have a vision of how the father experienced the care of the preterm child at home. The parents who did not live with their child after discharge and those who were not present on the day of consultation were excluded. It is noteworthy that all parents who met the inclusion criteria were invited to participate in the study, totaling 35 fathers. However, 11 fathers, at the time of collection, could not participate due to difficulties in attending the outpatient clinic to accompany their children as a result of work.

The mean duration of the interviews with participants was 30 minutes, considering the initial interaction and the interview itself.

It should be noted that one of the researchers was part of the care protocol execution team; however, she was excluded from conducting the interviews with the fathers in order to avoid conflicts of interest.

Data collection was performed by neonatal nursing residents, who were trained to do so, from July to October 2017, through semi-structured interviews containing two parts: the first, referring to the characterization of fathers and the second referring to the objective itself.

In the second part, three questions were elaborated common to both fathers participating or not in the protocol of care, namely: 1) Tell me how your child care related to housework and work activities are distributed? 2) Who has the most bond with the baby and why? 3) During your child's hospitalization, what care did you take? Talk about it. And a question designed specifically for participating parents: 4.1) Do you believe that taking care (such as bathing, oral hygiene, eye care, etc.) in the NITU/NICU had an influence on home care? Tell me about it. And another for parents not participating in the care protocol: 4.2) Do you believe that not having had the opportunity to perform care (such as bathing, oral hygiene, eye care, etc.) in the NITU/NICU had an influence on home care? Tell me about it.

To schedule the interviews, the researcher initially identified through a return schedule of the medical team which babies would be treated at the outpatient clinic that week. Subsequently, telephone contact was made with the father and/or mother of the preterm baby confirming the return date. At this time, the fathers were invited to participate in the research, being informed about the objectives, verifying the acceptance or not of the fathers to participate, and confirming the presence of the father in the consultation so that the research could be performed after the consultation. On the day of appointment, fathers were approached again reminding them about the research and confirming whether or not they would like to participate. The interviews were recorded using a voice recorder.

For the analysis, we considered the care established in the protocol that were performed by fathers and that they had mastery in its execution. Thus, fathers' participation in the household was compared according to the performance of basic care for the baby in his/her first year of life, such as feeding and hygiene assistance.

To identify the paternal experiences related to the care of preterm child at home for fathers participating or not in the protocol, the Collective Subject Discourse (CSD) is the methodological analysis chosen for the construction of meanings, allowing the approximation with the phenomenon under study.

The CSD is elaborated through fragments of various individual discourses. Each of the collective discourses is related to a specific position and opinion. It must be written in the first person singular tense so that it represents a collective idea.[8]

Three methodological figures were used for the research: the key expressions (KEs), the central idea (CI) and the collective subject discourse (CSD). KEs are literal passages of the statement that contain the essence of speech. The CI is the detailing of the meanings in the speeches. In the CSD there is a grouping of the KEs that are in the lines, which have complementary or similar anchorages and/or CI, representing the idea of the collective.[8]

The individual interviews were transcribed and subsequently readings of each speech were repeated repeatedly, in order to appropriate them and identify the KEs and then the CI.

For the formulation of the CSD, the KEs were grouped so that they formed a coherent discourse. For this, connectors were used in order to make sense of the CSD, without altering the sentence structure elaborated by the subject.

This research was initiated after approval by the Research Ethics Committee and after obtaining the informed consent form by the fathers participating in the study.

Aiming at the fathers anonymity and better understanding of the analysis performed, the name of the fathers participating in the care protocol was replaced by the acronym PS and for the non-participating parents the acronym PN was used. Then, the number corresponding to the order of the interviews was placed.

RESULTS

Twenty-four parents aged 20 to 58 years old participated in this study, 20 of whom were married and four living in a stable union. Of the 24 men, 15 were experiencing paternity for the first time and schooling ranged from incomplete elementary school to complete college. Of the total of parents, 13 had participated in the care protocol focused on the father figure during the preterm child hospitalization and 11 did not participate.

The time since discharge from preterm babies was from one month to one year. Their chronological age ranged from two months and 13 days old to one year, two months and 28 days old. Regarding the corrected age, the variation occurred from 24 days old to one year and 13 days old.

From the empirical material analyzed, ten CIs were identified, which were grouped into three themes: 1) Hospital care reflecting at home (CI1 - The care I did at the hospital helps me at home; CI2 - I stayed little, but I helped during hospitalization; CI3 - I help, but the mother does more); 2) Perception of the father regarding the construction of the affective bond (CI4 - Intense maternal bond; CI5 - Strengthening of the bond through care; IC6 - Sharing the affective bond; CI7 - Affection provided by the bond with the grandparents); 3) Barriers to paternal care (CI8 - The influence of paternal work; CI9 - Paternity leave and its influence on care; CI10 - Cultural aspects interfering with the performance of care).

Hospital care reflecting at home

Fathers who had the opportunity to participate in the protocol at the hospital reported that this care helped to overcome their fears and were important factors so that today they could help their partners with their children at home.

Parents who did not have the opportunity to participate in the care protocol reported that they were not in the hospital for a long time and performed some care such as skin-to-skin contact, diaper change and lapping. They stated that the partners remained more present, and did not consider this period as an influencing factor for care or not at home as can be observed in the following speeches.

CI1 - The care I did at the hospital helps me at home

DSC1: *At the hospital I learned how to change diapers, wipe the little eye, the little mouth, wash the nose with "little serum", give milk by the probe; then I learned how to milk with the glass, made the kangaroo, made the nest for him to sleep, took him in my arms, changed his clothes, I showered him, after I lost my fear. I spent hours talking to the baby and I'm sure he understood. All these care measures that I could perform in the hospital only showed more affection for him, hug him and so can pass this human warmth. When it was time to breastfeed, my wife who gave, but I helped her a lot at this time, always tried to be on the side because It has to give breast milk. I spent the night with my son in the hospital, but today I realize that having done all these cares helps me to take care of my son at home* (PS1-PS6, PS8-PS13).

The parents who participated in the protocol reported that having been oriented and inserted in their children's care during their hospitalization promoted greater security so that they could now take care at home with greater confidence.

CSD2: *Being guided and being able to take care of my son at the hospital helped to improve my care. I was already a father, so I already knew a few things, but I was well educated there; the fact that we live there inside the hospital leads us to learn many things we didn't know. Once you lose your fear a little, you become more confident in dealing with your child on a daily basis. We get more relaxed. I have never seen myself caring for a baby, especially a preterm baby. There, they gave us*

a lot of confidence. I see a very big difference. We were afraid to mess with the baby and today we are 100% less afraid (PS1-PS13).

However, some parents who participated in the care protocol differ from the experience that having performed care in the hospital environment favored home care, although they stated that having performed care during hospitalization allowed the improvement of care.

CSD3: *I don't know if it influenced the fact that I have performed care in the hospital because, regardless of whether I did it or not, I would have to take care of him at home. It was as if it had given me the practice, as if it were a course. At the hospital, I had nurses to help and teach.* (PS2, PS11).

The parents who did not participate in the care protocol also differ from the opinion that they would participate more effectively at home because of their participation in the hospital environment. They claim that they would not do this care because they are afraid.

CSD4: *No. It has nothing to do with me not doing it at the hospital, because at the hospital I wouldn't do it at all because I'm afraid. My wife says I don't do much, but if I have to, I do it, normally. Sometimes I help her bathe, change the diaper, give the bottle, hold in the arms, play. I do not believe that the fact that I did not perform care in the hospital influenced here at home; there are certain care that you would not perform here at home even if you had learned at the hospital.* [...] (PN1, PN2, PN4, PN5, PN7, PN10, PN11).

CI2 - I stayed little, but I helped during the hospitalization

CSD5: *At the hospital, I stayed a little; when I did it* (care) *it was a kangaroo, I got on my arms, changed diapers - just once - and helped my wife to bathe, but she was the one who stayed the most and did the caring for the baby* (PN1-PN4, PN8-PN10).

Fathers have been more involved in childcare and this is seen in the speeches below. In general, regardless of whether or not parents have participated in the care protocol, both report that they assist in the care of their children; however, they agree that mothers perform more care compared to them.

CI3 - I help, but mom does more

CSD6*: One helps the other, but mom ends up doing so much more than me. She is that "big mama" but as far as possible, I'm there helping, holding the baby, putting in the crib as she sleeps, helping to change the diaper. But the bath, I'm letting the mother do more because I'm afraid of letting slip; I also let the mother wash her nose and inhale - I don't know how to do that.* (PS1-PS4, PS6, PS8, PS9, PS12, PS13)

DSC7: *Sometimes mom is tired, wants to sleep, so I hold the baby in my arms. Sometimes I change diapers, give the bottle and shower, but the baby stays more with the mother. I take the baby for a walk and play a lot* (PN1, PN3-PN6, PN8, PN11).

Parents also reported that their participation is not restricted to caring for their children, but extends to performing household duties, and thus, believe that they enable their partners to be freer to care for the preterm baby. However, it is important to emphasize that this participation was more reported by parents who participated in the care protocol as opposed to non-participating parents as represented in CSD8 and 9.

CSD8*: Besides helping with the baby I also help in the household duties; we share the tasks. Every once in a while, I sweep the house, do the dishes, make dinner. I help cleaning, maintain the house, and help do all the things we have to do. At the time she is breastfeeding or the baby is sleeping we are there supporting both day and dawn as well. When I get home, I hold him and take care of him while my wife does the cleaning* (PS1-PS4, PS6, PS7, PS9-PS11).

DSC9: *When I'm home, I help my wife clean up, do the things she has to do. I do the dishes to help her* (PN4, PN7, PN11).

Regarding the construction of the affective bond, most fathers who participate or not in the care protocol realize that the mother has a greater bond because of the possibility of greater time availability and because they are the nursing mothers of children as shown below.

Father's perception regarding the construction of the affective bond

CI4 - Intense maternal bond

DSC10: *Oh, the bond will always be with the mother because she stays longer with the baby since it is born, and this bond is even greater during the breastfeeding period. I realize that with his mother he gets calmer and sometimes I am even jealous* (PS1, PS4, PS5, PS8-PS12).

CSD11: *The mother has greater bond with the baby because she stays longer with our son, the fact that she takes care of him since he was a little baby and for breastfeeding.* (PN2-PN6, PN9-PN11)

For some fathers, participation in care through the protocol helped them to develop paternity and to live it more fully, giving rise to a feeling of happiness and thus strengthening the bond between father and child.

CI5 - Strengthening of bond through care

CSD12*: Sometimes I was a little worried, insecure about manipulating her, so much so that when our daughter was hospitalized, we had no idea we could be manipulating her there - you imagine: we are father and mother seeing their daughter in the incubator and we can't touch her, just observing that people manipulate her. We understand that professionals need to take care of her, but I want to touch my daughter. I want to take her. But at the hospital it was pretty cool; First, we hear that it's usually only allowed for the mother to stay - the father usually just goes there to say "hello". I found it very interesting that they allowed me to do this; create an early bond with her too. And that's usually what they say: father is only father when he takes the baby in his arms. The mother has all that feeling, feels the baby growing inside the belly and the father is more out. I have other children, but I often say that today I feel like a father indeed, a real father. I think that performing care in the hospital made me feel like a father; I did participate and today I am very attached to this daughter* (PS1, PS2, PS7).

However, some parents, both those who participated and those who did not participate in the care protocol, disagree that the greater the bond of the child be with the mother, reporting that both have the same bond with the baby.

CI6 - Sharing the affective bond

CSD13*: I think we both have the same bond with our son, there is not that preference to be more father or more mother, baby likes us both the same way* (PS2, PS7).

CSD14: *Oh, it's hard to say* [...] *both of us. We both have a lot of love for him* (PN1, PN8).

CSD15*: Over a period of our lives my wife and I separated for about four months and this at first damaged my bond with my daughter, but then my wife and I resumed and today my daughter is very close to me. Sometimes she comes all loving wanting to be with me a little* (PS3, PS5, PS6).

However, some parents participating in the care protocol reported that they realize that their child's greatest bond is not related to them (father and mother), but is represented by other family members, such as grandparents.

CI7 - Affection provided by the bond with the grandparents

CSD16*: Our son is very fond of Grandpa; when he sees his grandfather it is a joy that looks like he will jump from our lap to his lap* (PS2, PS12).

However, fathers participating or not in the protocol refer to work as a barrier to child care. Some parents participating in the protocol reported being able to conciliate their work with the care of the baby at home, and even reduced their workload so they could experience this moment, as it can be seen below.

Barriers to paternal care

CI8 - The influence of paternal work

CSD17*: I work one part of the period and left the other period free, just to be helping my wife. When I get home my time is all theirs; I go there and help* (PS1, PS4, PS7, PS8).

In contrast, some parents who did not participate in the protocol at the hospital use work as a justification for not assisting in home care.

CSD18*: I work in the morning, then in the afternoon I rest. I work from Monday to Friday. Sometimes I work more than one period and only get home at night* (PN1, PN2).

However, parents who did not participate in the care of the baby verbalized that most of the care has been performed by the mother, and this fact generates for some of them the feeling of absence in the participation of child care due to work.

CSD19*: I think there's more left for mom, I work out home, I don't stay at there, so I feel absent at home. Sometimes I need to travel and stay for more than a day away from home, so I end up doing little care. I wish I had more time to stay with my son* (PN3-PN7, PN9-PN11).

For some fathers not participating in the care protocol, the short period of paternity leave was a factor that hindered their insertion in their child's care. Nonetheless, some do not know whether, if they had had more opportunities to learn about care, they would reduce their fears and insecurities.

CI9 - Paternity leave and its influence on care

CSD20*: My daughter spent a lot of time in the incubator, so I didn't do any kind of care, just the nurses. In addition, paternity leave is only five days and she was in hospital for almost a month, so I had to go back to work, so I spent less time there in the hospital. But anyway, I wouldn't have bathed her alone, because I'm afraid. I've always been afraid since my first child, but that has increased. I have a very heavy body, she is very 'soft'. I'm afraid of hurting her.* (PN1, PN2, PN4, PN5, PN7, PN11)

Other aspects were represented by fathers who were not part of the care as an obstacle to their perform the care, such as cultural factors; for example, some believe that a girl should only be cared for by her mother as can be seen from the speech below.

CI10 - Cultural aspects interfering with the performance of care

*DSC21: *As my daughter is a girl, I do not take much care; who bathes, changes the diaper, gives the bottle, makes sleeping, plays, walks, who does almost everything is my wife. I'm afraid and also ashamed, I think it's not normal.* (PN6, PN7, PN8, PN9)

DISCUSSION

In general, parents who have participated or not in the care protocol have contributed to the distribution of tasks, either by providing direct care to their child, such as diaper changes and feeding assistance, or by performing domestic activities in order to enable their partners to stay longer time taking care of their children.

Fathers participating in the care protocol reported the possibility of having care during the hospitalization of the preterm child as beneficial, as they provided them with greater security, reduced fear, making them more capable and competent for home care, as well as demonstrated in research conducted with fathers/men at hospital discharge from a Neonatal Intensive Care Unit of Colombia.[9]

In contrast, some non-protocol fathers have differing opinions stating that regardless of whether or not they could participate in this protocol, there would be no change in their participation at this time in their homes. Some fathers/men who participated in the care protocol agree with this statement, although they believe in the improvement of care that the protocol provided.

It is noteworthy that in a research conducted with fathers (men), where they could experience care during the hospitalization period of the preterm child, they pointed out these moments as favorable to strengthening the bond, because care represents a way to demonstrate their affection and love for the child, and it can be seen that they longed to be with the baby. Some men sought to somehow maintain physical contact with their child, such as touching and caressing him.[10]

It is important to point out that regardless of whether or not parents have participated in the care protocol, they have demonstrated bonding with their child in different ways. Some believe that the most intense bond occurs with the mother because she is the figure that spends more time with the baby, others report that the bond occurs equally between them and some realize that other family members may have a more significant bond than the parents themselves, such as grandparents. It is important to point out that the parents of the fathers in this study were housewifes, that is, none had jobs that could separate them from their children.

It is known that the mother has a strong bond with the child that usually begins during pregnancy, as observed in the speeches of some fathers. However, the father-child bond is further strengthened after hospital discharge and the child's arrival at home, when parenting is intensified and the affective bond with the baby strengthens. A home care assessment study shows that having a child at home is related to strengthening the feeling of being a father.[11] It is important that other family members, such as grandparents, be involved in improving the home care provided by these family members.[9]

In contrast, barriers to paternal care were represented in the speeches, mainly by parents not participating in the care protocol. The main barrier refers to the difficulty of conciliate work with the child care. However, for most parents who participated in the protocol, work was referred to as a factor that hinders greater availability but does not prevent them from performing care. On the other hand, fathers/men who did not participate in the protocol report that work is an important factor that makes it difficult for them to help in caring for their child at home.

The man assumes the role of economic provider of the family, and with this, the care of the child is limited, as they need to work to support the home. Thus, care is directed more to mothers, since they provide more time, which ends up reinforcing the role of women as caregivers of children, still predominant in the current social environment.[9] It is well known that women in many families have assumed the role of provider and not giving them the right to delegate care to their partner in many situations. However, in this study all fathers/men were the main provider and mothers played the role of caregivers because they are housewives, of these seven mothers had formal employment before

the birth of the child, but after the arrival of the child at home and due to need for special care along with their mates partners, they choose to leave their jobs to take care exclusively of the children.

The work makes the man realize that he does not spend enough time with his child, emerging feelings of unhappiness, dissatisfaction and stress. Father understands his social role as home provider through his work, but should also be a source of support for the partner, assisting with the care of older children, and assisting with the care of the preterm baby in the period of hospitalization as after discharge.[3]

This study also made it possible to verify as a barrier to paternal care the short period of paternity leave in return for the long period of hospitalization of the child, which hindered the possibility of participation in care in the hospital environment, thus hindering its full integration at this time. Paternity leave in Brazil is five working days after childbirth according to article 7th of the Federal Constitution of 1988;[12] however, this time is insufficient, especially facing the birth of a preterm child. However, there is a proposal to extend paternity leave to 20 days through the Early Childhood Legal Framework (PLC 14/2015) for workplaces that are part of the “Citizen Company” program.[13]

Some other causes for non-care by the father may be related to the fear of harming the preterm child, as they believe that because of their prematurity, they are dependent on specific and special care, as well as being fragile. Parents sometimes remember their child in the hospital environment and have difficulty understanding the time of transition to the home, which can be a stressful time, as it is a phase of uncertainty, insecurity and various concerns. Therefore, they need to be supported, trained and given information and guidance to improve care in the home environment and thus reduce the stress experienced at this stage.[9–10,14]

Cultural factors can also interfere with the care process, as the education and culture of each family can heterogeneously represent child care. An example of this was identified in this study in which some parents attributed non-participation in care because their child is of the opposite sex, which makes them uncomfortable to perform various cares, such as bathing or a diaper change. Therefore, one must take into account the personality, individuality, culture and beliefs of each father.[9]

The conception that women are the main actress of housework, domestic care, family and child rearing is still very present in our society. Thus, although some men have changed their posture to proactively and participatively position themselves in family life and routine, responsibility for caring for the home and children remains hopelessly associated with the figure of the woman.[15]

In this context, it is important that the nursing team, besides stimulating the fathers’ participation in the care of the preterm child in the hospital environment, empowers them to feel safe in the post-discharge care.[11,16] Thus, professionals need to stimulate the father’s participation regardless of how long he stays in the hospital environment, as well as implement the health policies that are being developed to encourage and value man as father, such as the companion’s prenatal care, which may favor the early emergence of paternity and the expansion of paternity leave.

This research has as limitation the fact that the study was conducted in only one location, using a protocol developed specifically for this neonatology service, not allowing to generalize the results.

CONCLUSION

It is noted that parents participating or not in the protocol have been performing child care as well as household activities, but report that the mother has more time available for child care compared to them. However, a significant number of parents participating in the protocol realized that the protocol had a positive influence on the care they perform today at home, stating that their insertion in the care of their children in the hospital environment provided greater security. In contrast, some believe that the fact that they did not participate in the protocol did not change their participation at home.

Parents report feelings of fear and insecurity regarding the performance of certain care at home, especially procedures considered complex by them, such as bathing, both fathers among the participating and non-participating in the protocol. In contrast, some participating fathers reported that they overcame their fear of some care due to the opportunity to have been included in their child's care during the hospitalization period.

The short period of paternity leave was mentioned by both participating fathers or not as a difficulty factor so that they could have participated more effectively in the care of their preterm child. In addition, cultural aspects and work were the main factors that hindered the presence of the father during hospitalization and in the care of the baby at home, since for the families of the study, the man was the main provider of the house, and from this, the woman was responsible for household duties and childcare.

REFERENCES

1. 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 Rev Enferm. [Internet]. 2015 [cited 2018 May 10];19(3):409-16. Available from: https://dx.doi.org/10.5935/1414-8145.20150054
2. Soares RLSF, Christoffel MM, Rodrigues EC, Machado MED, Cunha AL. The meanings of caring for pre-term children in the vision of male parents. Texto Contexto Enferm [Internet]. 2016 [cited 2018 Mar 18];25(4):e1680015. Available from: https://dx.doi.org/10.1590/0104-07072016001680015
3. Dadkhahtehrani T, Eskandari N, Khalajinia Z, Ahmari-Tehran, H. Experiences of Fathers with Inpatient Premature Neonates: Phenomenological Interpretative Analysis. Iran J Nurs Midwifery Res. [Internet]. 2018 [cited 2018 May 10]; 23(1):71-8. Available from: https://dx.doi.org/10.4103/ijnmr.IJNMR_21_17
4. Zani AV, Souza GG, Parada MCGL. Nacimiento y hospitalización del hijo pré-termo: sentimientos y emociones paternas. Rev Uruguaya Enferm [Internet]. 2016 [cited 2018 Mar 10]; 11(2). Available from: http://rue.fenf.edu.uy/index.php/rue/article/view/195
5. Marski BSL, Custodio N, Abreu FCP, Melo DF, Wernet M. Hospital discharge of premature newborns: the father's experience. Rev Bras Enferm [Internet]. 2016 [cited 2018 Jan 07]; 69(2):202-9. Available from: https://dx.doi.org/10.1590/0034-7167.2016690203i
6. Jodelet D. Loucuras e representações sociais. Petrópolis, RJ (BR): Vozes; 2005.
7. Silva TRS, Silva VCE, Parada MCGL, Zani AV. Validação de um instrumento de cuidados ao pré-termo voltado à figura paterna. REAS [Internet]. 2018 [cited 2018 June 27]; 10(3):1641-47. Available from: https://dx.doi.org/10.25248/REAS210_2018
8. Lefévre F, Lefévre AMC, Marques MCC. Discurso do sujeito coletivo, complexidade e auto-organização. Ciênc Saúde Coletiva [Internet]. 2009 [cited 2018 Jan 07]; 14(4). Available from: https://dx.doi.org/10.1590/S1413-81232009000400025

9. Osorio-Galeano SP, Ochoa-Marín SC, Semenic S. Preparing for post-discharge care of premature infants: Experiences of parents. Invest Educ Enferm [Internet]. 2017 [cited 2018 Apr 27]; 35(1):100-8. Available from: https://dx.doi.org/10.17533/udea.iee.v35n1a12

10. Medeiros FB, Piccinini CA. Father-infant relationship in the context of preterm birth: pregnancy, hospitalization and third month after discharge. Estud psicol [Internet]. 2015 [cited 2018 May 15]; 32(3):475-85. Available from: https://dx.doi.org/10.1590/0103-166X2015000300012

11. Lundqvist P, Hellstrom-Westas L, Hallstrom I. Reorganizing life: A qualitative study of fathers' lived experience in the 3 years subsequent to the very preterm birth of their child. J Pediatr Nurs [Internet]. 2014 [cited 2018 Apr 29]; 29(2):124-31. Available from: https://dx.doi.org/10.1016/j.pedn.2013.10.008

12. Brasil. Constituição, 1988. Constituição da República Federativa do Brasil [Internet]. Brasília, DF(BR): Senado; 1988. [cited 2018 June 15]. Available from: http://www2.camara.leg.br/legin/fed/consti/1988/constituicao-1988-5-outubro-1988-322142-publicacaooriginal-1-pl.html.

13. Brasil. Projeto de Lei da Câmara nº 14, de 2015: dispõe sobre as políticas públicas para a primeira infância, altera a lei n° 8.069, de 13 de Julho de 1990, que dispõe sobre o Estatuto da Criança e do Adolescente, o Decreto-Lei n° 3.689, de 3 de Outubro de 1941 - Código de Processo Penal, a Consolidação das Leis do Trabalho - CLT, aprovada pelo Decreto-Lei n° 5.452, de 1° de Maio de 1943, a Lei n° 11.770, de 9 de Setembro de 2008, e a Lei n° 12.662, de 5 de Junho de 2012. Brasília, DF(BR); 2015 [cited 2018 June 15]. Available from: https://www25.senado.leg.br/web/atividade/materias/-/materia/120182/pdf.

14. Garfield CF, Lee Y, Kim HN. Paternal and maternal concerns for their very low-birth-weight infants transitioning from the NICU to home. J Perinatal Neonatal Nurs [Internet]. 2014 [cited 2018 May 28]; 28(4):305-12. Available from: https://dx.doi.org/10.1097/JPN.0000000000000021

15. Rodrigues BC, Lima MF, Maschio Neto B, Oliveira GL, Corrêa ACP, Higarashi IH. Being a mother and a nurse: issues about gender and overlapping social roles. Rev Rene. [Internet]. 2017 [cited 2019 May 24]; 18(1):91-8. Available from: https://dx.doi.org/10.15253/2175-6783.2017000100013

16. Ingram J, Redshaw M, Manns S, Beasant L, Johnson D, Fleming P, et al. "Giving us hope": Parent and neonatal staff views and expectations of a planned family-centred discharge process (Train-to-Home). Health Expect [Internet]. 2017 [cited 2018 May 07]; 20(4):751-9. Available from: https://dx.doi.org/10.1111/hex.12514

NOTES

ORIGIN OF THE ARTICLE

Extracted from the dissertation - Hospital protocol of premature baby care: paternal experiences and maternal perceptions after discharge, presented to the Nursing Program in *Universidade Estadual de Londrina*, in 2018.

CONTRIBUTION OF AUTHORITY

Study desing: Mathiolli C, Zani AV.
Data collection: Mathiolli C, Zani AV.
Analysis and interpretation of data: Mathiolli C, Ferrari, RAP, Parada CMGL, Zani AV.
Discussion of the results: Mathiolli C, Ferrari, RAP, Parada CMGL, Zani AV.
Writing and/or critical review of content: Mathiolli C, Ferrari, RAP, Parada CMGL, Zani AV.
Review and final approval of the final version: Mathiolli C, Ferrari, RAP, Parada CMGL, Zani AV.

ACKNOWLEDGMENT

To parents participating in the study.

FUNDING INFORMATION

Funded by the National Cuncil for Scientific and Technological Development (CNPq) case No. 448117/2014-2.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of the *Universidade Estadual de Londrina*, opinion No.694,303 (CAAE - 30709814.0.0000.5231)

CONFLICT OF INTEREST

There is no conflict of interest.

HISTORY

Received: March 08, 2019
Approved: July 26, 2019

CORRESPONDING AUTHOR

Carolina Mathiolli
carolina_mathiolli@hotmail.com