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PRÁTICA SOCIAL DA ENFERMAGEM NA PROMOÇÃO DO CUIDADO MATERNO AO PREMATURO NA UNIDADE NEONATAL1

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THE NURSING SOCIAL PRACTICE IN THE PROMOTION OF MATERNAL CARE TO THE PREMATURE IN THE NEONATAL UNIT[1]

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ABSTRACT

Objective: to describe the ways of promoting maternal care by the nursing team of a neonatal unit and analyze the ways of promoting this care and its interface with public policies.

Method: a descriptive and exploratory study, with a qualitative approach, developed with 15 professionals of the nursing team who worked in the care of premature babies and their families in the neonatal unit of a university hospital located in the city of Rio de Janeiro (Brazil). The results were analyzed according to the critical analysis of discourse and interpreted under the light of the theoretical conceptions of Paulo Freire.

Results: the social practice of nursing professionals in the promotion of maternal care was based on three modes of promotion: making them understand, making them feel and doing, and showed to be linked to the institutional ideology articulated with the public policies towards mothers in Brazil. In this sense, the modes of promotion of maternal care were directed to the fulfillment of functionalist objectives linked to specific programs, not considering the maternal demands. The discourses affiliated with a dominant ideology revealed the professionals' power relations with their mothers, with a view to meeting the promotion strategies that make up the National Breastfeeding Incentive Policy in Hospital Care, with the support of the Baby Friendly Hospital Initiative and the Kangaroo Method.

Conclusion: the nurse needs to recognize the needs of mothers in the care of the premature newborn and to promote their potential skills so that they can care for their children in the neonatal unit.

DESCRIPTORS: Infant, Premature. Nursing, team. Intensive care units, Neonatal. Mothers. Neonatal nursing.

A PRÁTICA SOCIAL DA ENFERMAGEM NA PROMOÇÃO DO CUIDADO MATERNO AO PREMATURO NA UNIDADE NEONATAL

RESUMO

Objetivo: descrever os modos de promoção do cuidado materno pela equipe de enfermagem de uma unidade neonatal e analisar os modos de promoção desse cuidado e sua interface com as políticas públicas.

Método: estudo do tipo descritivo e exploratório, com abordagem qualitativa, desenvolvida com 15 profissionais da equipe de enfermagem que atuavam na assistência ao bebê prematuro e sua família na unidade neonatal de um hospital universitário, localizado na cidade do Rio de Janeiro (Brasil). Os resultados foram analisados segundo a análise crítica de discurso e interpretados à luz das concepções teóricas de Paulo Freire.

Resultados: a prática social dos profissionais de enfermagem na promoção do cuidado materno foi alicerçada em três modos de promoção: fazer entender, fazer sentir e fazer fazer, e se mostrou vinculada à ideologia institucional articulada com as políticas públicas para com as mães, vigentes no Brasil. Nesse sentido, os modos de promoção do cuidado materno estavam direcionados ao cumprimento de objetivos funcionalistas vinculados a Programas específicos, não considerando as demandas maternas. Os discursos filiados a uma ideologia dominante revelaram as relações de poder dos profissionais para com as mães, com vistas ao atendimento das estratégias de promoção que compõem a Política Nacional de Incentivo ao Aleitamento Materno na Atenção Hospitalar, tendo como apoio a Iniciativa Hospital Amigo da Criança e o Método Canguru.

Conclusão: o enfermeiro precisa reconhecer as necessidades das mães frente ao cuidado ao recém-nascido prematuro e favorecer suas potencialidades, para que sejam capazes de cuidar de seus filhos na unidade neonatal.

DESCRITORES: Recém-nascido prematuro. Equipe de enfermagem. Unidades de terapia intensiva Neonatal. Mães. Enfermagem neonatal.

LA PRÁCTICA SOCIAL DE LA ENFERMERÍA EN LA PROMOCIÓN DEL CUIDADO MATERNO AL PREMATURO EN LA UNIDAD NEONATAL

RESUMEN

Objetivo: describir los modos de promoción del cuidado materno por el equipo de enfermería de una unidad neonatal y analizar los modos de promoción de ese cuidado y su interfaz con las políticas públicas.

Método: estudio del tipo descriptivo y exploratorio, con abordaje cualitativo, desarrollado con 15 profesionales del equipo de enfermería que actuaban en la asistencia al bebé prematuro y su familia en la unidad neonatal de un hospital universitario, ubicado en la ciudad de Río de Janeiro. Los resultados fueron analizados según el análisis crítico de discurso e interpretados a la luz de las concepciones teóricas de Paulo Freire.

Resultados: la práctica social de los profesionales de enfermería en la promoción del cuidado materno se fundó en tres modos de promoción: hacer entender, hacer sentir y hacer hacer, y se mostró vinculada a la ideología institucional articulada con las políticas públicas para las madres, Brasil. En ese sentido, los modos de promoción del cuidado materno estaban dirigidos al cumplimiento de objetivos funcionalistas vinculados a programas específicos, no considerando las demandas maternas. Los discursos afiliados a una ideología dominante revelaron las relaciones de poder de los profesionales con las madres, con miras a la atención de las estrategias de promoción que componen la Política Nacional de Incentivo a la Lactancia Materna en la Atención Hospitalaria, teniendo como apoyo la Iniciativa Hospital Amigo del Niño y el Método de Canguro.

Conclusión: el enfermero necesita reconocer las necesidades de las madres frente al cuidado al recién nacido prematuro y favorecer sus potencialidades, para que sean capaces de cuidar de sus hijos en la unidad neonatal.

DESCRIPTORES: Recién nacido prematuro. Equipo de enfermería. Unidades de terapia intensiva neonatal. Madres. Enfermería neonatal.

INTRODUCTION

It is estimated that currently 15 million premature births occur worldwide and that approximately 1 million children die because of complications of prematurity, which is the leading cause of death in children under five years of age. Brazil is in the 10th place in the world in number of premature births and the in the 16th place in deaths due to complications of prematurity. Thus, approximately 350,000 newborns are premature, accounting for about 12% of births in the country.[1-2]

In this context, investments in technology and specialized care, as well as current public policies, have ensured the survival of newborns with ever lower gestational age and weight and, given this new possibility of care, reveal the fragility and vulnerability of these immature beings since their birth. In this way, functional disorders, neurological, cognitive, sensory and motor alterations, as well as the delay in growth and development and the consequent social and family repercussions, have become a public health problem.[3]

Therefore, the inclusion of premature discharge from intensive care in society represents a challenge, which involves a series of factors related to mental, social and family health. In this sense, the family – and especially the mother – should be considered as an active agent in the process of growth and development of the premature child from birth.[4]

Given the prematurity of the child, it is necessary for the mother to receive support to know him, so that she identifies his skills, abilities and responses in the interaction with the environment.[5] In this way, this support can be offered through maternal care, to bring the mother to the center of care.[6]

Maternal care is a set of environmental and biopsychosocial actions that provide integral care for the mother and her child, so that the child can develop well alongside her. It contributes to the physical and emotional development of the baby, improvement in the clinical treatment with consequences in the reduction of hospitalization time, in the hospital costs, as well as in the number of readmissions in the hospitals.[1,4]

Maternal care in childhood still brings benefits to the child's future mental health, and this warm and intimate relationship between the baby and his mother, in which both find pleasure and satisfaction, is responsible for building a solid foundation that will positively influence development of the child's personality.[7]

The commitment of maternal care to her infant is correlated to the bonds of affection created between the mother and the child. Likewise, when the mother can see the child, touch him and care for him, there is a narrowing of these affective bonds, which enables the mother to become committed to the child, who is under her care.[8] Thus, this maternal affectivity and commitment enable the development of sacrifices, indispensable for the care of the newborn, in order to confer protection, concern and provision of this needs to the detriment of their own needs.[3]

Therefore, maternal care is extremely necessary for the growth and development of the premature neonate, and the nursing team should promote a dialogue relationship with the mothers, to instrumentalize them for the participation of the child in

an autonomous way, favoring an appropriate, effective, emancipatory and responsible perspective.[4]

In order to identify the studies that dealt with the subject of maternal care to the newborn, a search was made in the scientific literature, and 11 studies were selected, which focused on the nursing care of the newborn/infant by the nursing team, the feelings and experiences of the parents in the neonatal unit (NU), advise manuals for the parents, professional-mother relationship during the hospitalization of the child, evidencing the need to discuss the promotion of maternal care to the newborn in the NU.

Therefore, the objectives of this study were to describe the ways of promoting maternal care by the nursing team of a neonatal unit and to analyze the ways of promoting this care and its interface with public policies.

METHOD

A descriptive and exploratory study, with a qualitative approach, directed at the level of reality that cannot be quantified. The exploratory type of study is indicated in little studied problems, on which there is little or no developed knowledge.[9]

It is understood that nursing professionals, when promoting maternal care, use tools and strategies based on educational models, aiming at health education. Considering this practice as an integrative pathway of maternal care, it should constitute a space for reflection-action, that propitiates the mother's autonomy and emancipation to care for her child whether in the hospital or home space, Freire was chosen as the theoretical support of this study.[10]

The setting was the NU of the Maternity Hospital of a University Hospital, located in the city of Rio de Janeiro (Brazil), accredited by the Baby Friendly Hospital initiative. This unit has the main purpose of assisting the newborn at risk, developing teaching and research and being a reference to all types of medical specialties.

The NU is subdivided into two sectors: The intermediate unit (IU) and the neonatal intensive care Unit (NICU). It has 14 beds in its structure, and the IU has capacity for eight beds, totaling 22 beds. It still offers a room with six beds called nursing home or puerperal room, which corresponds to an area intended for the full stay of mothers, who have had obstetrics discharge and have their babies hospitalized.

This unit does not offer kangaroo intermediate care unit but promotes the first stage of the Kangaroo Method as early as possible. It also allows the free access of mothers and fathers, making possible the visits of the brothers and grandparents daily, from 2 pm to 3 pm.

Fifteen professionals of the nursing team participated. The following inclusion criteria were defined: those who were directly involved in the care of the premature baby and his/her family in the NICU and IU during the data collection period, with a period of service of at least one year in the NU. Exclusion criteria were the nursing professionals who worked at the time of the research in the administrative function of the NU and trainee nurses. The professionals did not give up or refused to participate in the research.

The sampling criterion was based on the comparison with the studies located in the scientific literature presented in this research, having as participants the professionals of the nursing or health team and who were developed from the qualitative approach. Thus, from the sample of studies published in the literature, there were 12 to 23 participants. Thus, the external reliability of this study occurred due to the number of participants in the study, which totaled 15 professionals from the nursing team. Regarding the inclusion of the participants of the research, the study approached approximately 25% of the professionals of the nursing team.

The approach with the participants were carried out personally in the NU, during the performance of the shift, when an empathic relationship with the professionals was attempted. At that moment detailed information about the research, its objectives and commitments of the researcher were explained.

Following these guidelines, the invitation to the members of the nursing team that fulfilled the inclusion criteria was formalized. These professionals were informed in detail about the Informed Consent Form (ICF) and about the use that would be made of the research data. The ICF was signed in two counterparts, one owned by the researcher, and the other one delivered to the research participant.

The speeches were obtained by means of a semi-structured interview, using MP4 recorder, during the period from January to April 2015. The place of the interviews was quiet and private, with only the researcher and the participant interviewed. An interview script with open and closed questions was used. The closed questions were aimed at the identification of the professional, and the open ones to meet the objectives of the research. The interview

lasted an average of 30 minutes and contained the following questions: What do you consider maternal care? How do you promote maternal care in the NU?

The research was approved by the Ethics and Research Committee of the institution under Opinion 639.462. The ethical principles established for research involving human beings were respected, privacy and anonymity of the interviewees were ensured throughout the time, for which letters and numbers were used to identify them.

The Critical Discourse Analysis (CDA) was adopted[11] as support for the analysis of empirical data, since the discursive practices pointed out elements of the social macrostructure, which made us opt for discourse analysis in a critical and ideological way.

CDA is an analysis of macroscopic tradition and with interpretative characteristics, which seeks to analyze the institutional and organizational circumstances of the discursive event and to identify how they shape the nature of discursive practice.[11]

According to CDA, any discursive event can be analyzed from three dimensions. In the first dimension, which is the tradition of textual and linguistic analysis, it is sought to highlight the characteristics of vocabulary, grammar, cohesion and textual structure.[11]

In the second dimension, called discursive practice, one should consider the discursive practice of the subject as something produced, apprehended and shared consensually among people. This can be detected by the presence of other specific texts in the text to be analyzed – characterizing intertextuality –, or by means of the identification, in the discourse under analysis, of the presence of other discursive fragments reproduced before, elsewhere, by another person, thus characterizing interdiscursivity.[12]

And the third dimension, named social practice or context, comprises the analysis of the discursive event as an instance of social practice, and has as its general objective to make clear the nature of the social practice in which the discursive practice is constituted. To understand the social matrix of discourse, political and ideological orders and effects, we seek to reflect on discursive practice and its effects on social practice.[11]

Thus, discourse as a social practice is the understanding that language and discursive practices are invested ideologically insofar as they incorporate meanings that contribute to maintaining or (re)structuring relations of power. Thus, in the operationalization of the analysis process, after the transcription of the interviews, the material for exploration, treatment and interpretation of the results obtained was started. Afterwards, the classification of the speech was performed by means of a colorimetric method; that is, words and expressions with the same meaning were colored with the same color.[12]

Afterwards, to understand how discursively the modes of promotion of maternal care in the NU were constructed discursively, we tried to identify linguistic marks that evidenced this construction. In the analysis of the speeches, it was initially observed that most of the actions attributed to nursing professionals were constituted as verbal actions. At the second moment, we sought the discursive objects referring to the discursive practice of nursing professionals; for that, we used the tools of interdiscursivity and intertextuality manifested. And in the third moment it was tried to evidence, in the discursive practice of the nursing team, the social practice constitutive of power relations and the ideologies present in the promotion of maternal care.

Understanding that the promotion of maternal care requires a health education based on the pedagogical political process subsidized by critical and reflexive thinking in order to propose transformative actions that lead to autonomy and maternal emancipation – as a historical and social subject capable of proposing and giving an opinion on health decisions to take care of herself and her child –, was used to interpret the results of this study the theoretical reference of the problematizing education of Paulo Freire.[10]

RESULTS

From the 15 participants in the research, seven were nurses and eight were nursing technicians who worked directly in the care of premature babies and their families in the NICU and IU, in the period of data collection. The time in the sector ranged from 1 to 33 years.

The speeches of nursing professionals are presented below, containing the modes of promotion of maternal care in the NU.

Discursive representations of nursing professionals pointing to the ways of promoting maternal care in the neonatal unit

Considering that, in several contexts, verbal items were insufficient to enable the intended categorization, it was extended to the analysis of the expression composed by the verb and its complement. From this previous survey of verbs and their

complements, it was possible to deduce groups of semantic traits or senses shared by recurrent verbs, which described actions of promotion of maternal care developed by nursing professionals, indicating three dimensions, which are: to make understand, to make feel and do, as is evident in the table.

Table 1 – Categorization of verbs according to the type of action intended

Senses unveiled	Verbs practiced
Make understand	Speak Clarify Explain Teach
Make feel	Help Talk Approach Promote Speak
Do make	Encourage Ask Show Ask Insert Assist

The social practices of nursing professionals in the promotion of maternal care were based on three modes of promotion: to make understand, to make feel and to have it done. These modes of promotion pointed to an ideological formation structure hierarchically affiliated with the pro-breastfeeding public policies.

With the sense of making understand, the nursing professionals clarified, spoke, taught, and explained to mothers:

[...] *little by little she understands that it is a process that he is going through* [...] *we will work together for that baby to improve, to clarify, from there she will understand, she goes putting her hand, she begins the relationship with the baby care. The maximum care they take is to change a diaper, to hold a syringe at the time of gavage, to calm the baby when the baby is stressed* (E.1).

I explain the importance of the kangaroo method [...] *I always tell them: 'You stay calm, you have to be well, if you are very anxious, very nervous with breastfeeding you, in addition to the milk drying, you will not be able to concentrate in his care. Breastfeeding is very important to him, but the most important thing is to be here'* (E.2).

[...] *we are teaching and accompanying so that she can do it under supervision, at first a more attentive supervision and then a little more distant so that she also has, can take initiative, has a little freedom* (E. 8).

I explain, advise: 'Look, this is how he has to stay to get it, to breastfeed, it's this motherly position' [...] (E.11).

Looking at the discursive fragments, one can see that the verbs *speak*, *clarify*, *explain* and *teach* present themselves in the same semantic field in all actions, because it determines that an action is being taken to another person to make them understand. Thus, to make them understand, professionals indicate, in their discursive fragments relevant actions to inform the possibilities of child care, revealing ways of approaching mother and child linked to the recommendations of public policies to encourage breastfeeding.

In relation to the sense of *making feel*, the nursing team approached:

helping to gavage the diet, to make non-nutritive suction, always talk that non-nutritive sucking is important pro baby, that often the baby is stressed, it is a form of pain relief, he feels more comfortable. The question of diet gavage is also very important for the mother that the fact that she cannot breastfeed the baby yet, the baby is not yet available to suck the breast, then the mother feels also participating in the baby's feeding (E.2).

we always try to approach the mother of the baby even to promote this bond that is super important. [...] *Well, since, right? the beginning, when the NB arrives here for us, we always try to approach with the family, with the mother, especially in the care. Super important the nursing team is even approaching the mother of her baby, as we have here in the NICU, the mother is afraid to arrive* [...] *Yes, yes* (E.7).

while they are giving the cup and then you get scared. Hence, I say: 'No, we will give the cup, yes, we'll put it stand, sit him down, that's the way...' A whole procedure in advice, in supervision; we are always there on her side, so this is very important to them. I believe it is [important to them]*, they leave here very grateful* (E. 11).

Looking at the speeches, it can be shown that the verbs help, converse, approximate, promote, speak have the same semantic field in all actions, because it determines that an action is being taken to another person in the sense of making them feel. In this sense, the actions revealed in the professionals' speeches show the mother's approach, involvement and participation associated with the public policy of encouragement, protection and support to breastfeeding in hospital care.

In the sense of making do, the nursing professionals encouraged, asked, showed, asked for, inserted and helped:

encouraging breastfeeding [...] *I wonder if she* [the

mother] *wants to change the child's diaper if she feels like doing* [Kangaroo method], *if she has already been to the milk bank, if she is willing to breastfeed.* [...] *I show what the touch should be like* [in the baby] (E.2).

diet per cup too, I ask her to do it and I'm always supervising (E.6).

inserting the mother even more into the care. [...] *Let the mother accompany the gavage* [...] *and we are there looking. Just to have the taste of feeding the baby* (E.8).

placing what is more practical, easier for her. [...] *Normally in the changing of the diaper, helping to gavage a diet or if it is in the bottle, to encourage her in the bottle, plus the basic care as well* (E. 12).

Looking at the discursive fragments, it is understood that the verbs encourage, ask, show, insert, help have the same semantic field in all actions, because it determines that an action is being taken to another person in the sense of making do. Thus, the professionals of the nursing team in the sense of making do bring in their speeches actions that are linked once again to the public policies for breastfeeding.

DISCUSSION

In promoting maternal care, the nursing professionals use communication tools, such as explanation, advise and encouragement, seeking to contemplate the public policies related to breastfeeding.

In this sense, the speeches reflect the promotion strategies that make up the National Breastfeeding Incentive Program (PNIAM) in Hospital Care, with the support of the Baby Friendly Hospital Initiative (BFHI) and the Humanized Attention to the Newborn - Low Weight Infant - Kangaroo Method, also counting on the Brazilian Network of Human Milk Bank (RBBLH).[12-15]

The BFHI is part of the Global Strategy for Infant and Young Child Feeding, World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), which seeks renewed support for exclusive breastfeeding of the child up to six months of age, and continued breastfeeding with complementary feeding for two years or more. This Initiative has emerged because of health events and policies, with the purpose of rescuing the practices of breastfeeding and combat the high consumption rates of milk formulas, associated to a great part of the world infant mortality.[13]

In this sense, health professionals, when reassuring mothers at the time of breastfeeding, indicating the disadvantage of the emotional condition in milk production, try to contemplate what is proposed in step 5, for successful breastfeeding of BFHI, which is show mothers how to breastfeed and maintain lactation, even if they become separated from their children.[15]

However, by adopting prescriptive behavior, determining what the mother should do, how she should feel and conduct care, practitioners adopt a vertical posture, typical of a banking education.[10]

Thus, the professional, when promoting maternal care, defines the content or goal to be achieved, establishing behaviors to be fulfilled by the mothers, according to the discursive fragments: I ask if she has already been to the milk bank; stay calm, you have to be well; that's how he has to be (when he's being breastfed).

When using banking education to promote maternal care, nursing professionals do not always reach the objectives set forth previously, since, when speaking to the mother that she should be well, emphasizing the negative consequences of the anxiety presented by her, can generate even more anxiety and consequently hamper maternal care. Likewise, when determining the position of the child in the breast, without valuing the maternal prior knowledge, they eventually remove from the mother the possibility of trying the best position for her and her child.

On the other hand, in the problematizing education one looks for , through dialogue, and based on the culture of the student and the awareness that he has, the theme to be worked on. And thus, through a dialogical relationship between educator and learners, it allows the individuals' awareness of the themes and the reflection on their own reality to be obtained, allowing their criticism and transformation.[10]

Other strategies, presented in the professionals' speeches, aimed at attending the fifth step of the BFHI, are the incentive to the participation of the mother in the administration of the diet by gavage, the application of non-nutritive sucking to the child, the realization of the diet by cup, and translactation. These actions make it possible for the mother to participate in the feeding of the child, contributing positively to the maintenance of milk production even if breastfeeding is not possible at that moment.[15-16]

In bringing these strategies, the professionals' speeches also meet the requirements of the Humanized Assistance Program for the low birth weight - Kangaroo Method, when it states that, to contribute to the formation of lasting affective bonds, the team

should allow parents to participate in the care given to the baby, and also proposes strategies of reminders advising the professional to coincide the visit of the parents with the feeding of the baby.[14]

It is worth noting, in the speeches, that the professionals also gave the mother the possibility to gavage the diet in the occasion of the unavailability of the baby to suck the breast, as well as the realization of the translation for the mother to have the taste of being feeding the baby, corroborating for stimulating early lactation.

Thus, when they help the mother to perform nonnutritive sucking and emphasize the importance of this practice to relieve pain and comfort of the newborn, the professionals contemplate the special care recommended in the first stage of the Program of Humanized Assistance to the Low Birth Weight Neonate Method Kangaroo: ensure the baby measures of protection of stress and pain.[14]

When bringing the cup as a food alternative used in the NU, the speeches are part of the BFHI policy, which recommends, in its guideline, that the supply of breastmilk may be accomplished by breastfeeding, or supplemented with human milk by feeding tube, spoon or cup, according to the clinical conditions of the mother-baby binomial.[15-16]

The cup technique is an appropriate method of feeding newborns when they cannot yet be breastfed in the mother's womb, or when the mother is unable to breastfeed her infant. This form of feeding is widely used in preterm infants, with the purpose of avoiding the offering of Human Milk using bottle nozzles, avoiding the confusion of nozzles and probable weaning. The cup is still intended to increase effective sucking ability for breastfeeding, and corroborate the success of breastfeeding, even in situations of mother-baby distancing.[16-17]

Another way to promote maternal care, present in the professionals' speeches, was related to maternal referral to the Human Milk Bank (BLH). The BLH is part of the strategy of RBBLH's government breastfeeding promotion policy, which, in addition to collecting, sorting, classifying, processing and distributing human milk, still aids at any time to infants who find it difficult to breastfeed their hospitalized children. The BLH offers a specialized service linked to a hospital for maternal and/or child care, being prohibited the commercialization of the products distributed by it.[18-19]

The speeches also revealed actions pertinent to guidelines on the hand and position recommended by PNIAM and that are present as actions to promote breastfeeding in the IHAC, Kangaroo Method and RBBLH strategies.[20]

However, despite seeking to contemplate the objectives of PNIAM, health professionals revealed, in his speeches, which consider some aspects to establish possible care to be performed by the mother. Thus, in bringing "maximum care", the professionals' speeches indicates that not all care is possible to be performed by the mother, being limited only to hygiene care and food.

In addition to the professional carrying out the promotion of this maternal care in the perspective of a technicist care, to meet the goals of current public policies, this care is still restricted and specific, and it is evident in the speeches that the mother is not the most appropriate person to care for her own child at the moment.

Thus, the favorable relationship established between the professional and the mother, in which the professional behaves in such a way as to enable him or her to take care of the child and himself, feel grateful for the opportunity. This favorable relationship well portrays the power relationship that exists in this scenario.

In this relationship between oppressor and oppressed, there is no room for dialogue. The professional alone decides what the mother can and cannot do and what kind of care she performs, thus revealing that the promotion of care does not allow autonomy to the mother.[10]

In this way, the senses present in this relationship are of an ideological character, since they contribute to the naturalization of the differences that interiorizes and serve as discrimination to certain groups, in an imperceptible way so that there is no ideological struggle.[11]

The speeches also pointed out that, on the maternal impossibility of breastfeeding the child, the professionals stimulate the mother's participation in the administration of the diet through gavage so that they feel participating in the feeding of the child. Thus, the professional's need to stimulate this sense of maternal participation in gavage feeding reveals the valorization of the idealization of breastfeeding as something normally expected and that, in a way, includes the mother in the care process. However, when breastfeeding is not possible, there is an adaptation of the promotion actions to stimulate gavage, so that the mother has the sensation and "taste" to be participating in the feeding of the baby.

However, by using the terms "feel also participating in feeding the baby" and "just so she has the taste of feeding the baby", it is pointed out that

for the professional the mother's participation does not actually happen and that she is only given the feeling of being involved.

The speeches also revealed the demarcation of the presence of the professional in the actions of maternal care. As they were supervising, looking and "always there by the side", bring up the possibility of supporting the action of maternal care or monitoring the mothers in performing this care.

Thus, in teaching the mother to give the cup, the professional revealed in his speech that he guides, supervises and stands next to the mother, noting that these actions to promote care are very important for her. However, in showing that this promotion is important, the professional reveals an education policy that does take the mother into account as a collaborator but rather as a passive subject of the process, in which the professional allows all the conditions, which says when, what, why and how each care should be done. The actions to promote maternal care are still directed towards the fulfillment of functionalist objectives linked to specific programs, seeking to attend to the steps, strategies and routines without understanding how the care process will unfold within the maternal context and reality.[10,20]

This situation is evidenced by another study, which suggests the difficulty of the nursing team in renouncing power in relation to care, instituting a vertical relationship, based on resistance to the insertion of the relative.[21-22]

Therefore, by the recognition of the nurse as a professional capable of encouraging maternal autonomy in the care of the premature child through the promotion of maternal care – aiming at empowerment during hospitalization –, it is necessary that in this process the professional glimpses another look, the one for which the mother is an active subject of the process, can be heard, thus enabling the planning of care together with the team.[22-25]

CONCLUSION

The social practice of nursing professionals in the promotion of maternal care to the premature neonate has been linked to institutional ideologies articulated with the public policies in force in Brazil. Being the scenario of the study accredited with the BFHI, the discourses reflect ways of promoting maternal care that compose the PNIAM in Hospital Attention, having as support the Humanized Assistance Program to the Low-Weight Newborn - Kangaroo Method, counting on the RBBLH.

Even though professionals carry out the promotion of maternal care with a view to complying with current policies, these modes of promotion of maternal care have still been restricted to the fulfillment of functionalist objectives linked to specific programs, when seeking to meet steps, strategies and routines, they did not consider maternal needs and demands.

In this way, the participation of the mother in the care of the child was determined by the professionals, who established the possible care of the mother, often limited to, hygiene and food. These permitted modes of care were taught, provided, and overseen by professionals to give the mother the feeling of being in care for her child.

This possibility of maternal care, established by the professional, who decides the moment, the action, the purpose and the way of performing each maternal care, unveils an education policy that keeps the mother as the subject of the process. Besides that, when adopting vertical and prescription actions aiming at caring the institutional demands against the maternal needs, the nursing professionals reinforced their power relationships in comparison to the mothers.

This study presents the limitations of a qualitative investigation, since this methodology does not aim at measuring and generalizing the investigated facts. Besides the fact of it being done only with professionals involved and hospital assistance of an institution which has the BFHI title, a limiting factor of the study, once the research in other settings may point to practices, applying the comprehension of the studied situation.

However, it offers contributions to the nursing practice, since it provides subsides to the reflexion of the nursing professionals before the promotion of the mother's care to the premature newborn in the NU – so as to surpass the ideologic idea predominant in this care setting –, and from there to rethink its practices aiming at adjust them in favor of the mother as an active subject in the process of caring of her child when in the NU.

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