Parental perceptions of beliefs and care practices for children born prematurely

Percepções parentais sobre crenças e práticas de cuidado com crianças nascidas prematuras

Percepciones parentales sobre creencias y prácticas de cuidado de niños nacidos prematuros

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Abstract

Objective: To analyze parents' perceptions regarding beliefs and practices in the care of children born prematurely, correlating them with child developmental milestones.

Methods: This survey-type study was conducted with parents of premature children up to three years of age. Data were collected using instruments available on the REDCap platform, including a sociodemographic questionnaire, perinatal and neonatal variables, and the Parental Beliefs and Care Practices Scale (E-CPPC). Data were analyzed using descriptive statistics; to assess associations, Pearson's Chi-square test or Fisher's exact test were used (significance level: 5%).

Results: A total of 30 mothers participated, and 46.6% of the children were born extremely or moderately preterm. Mothers showed greater appreciation for practices aimed at immediate physical well-being (such as keeping children clean and preventing accidents), to the detriment of cognitive stimulation (such as reading books or playing with them). However, direct interaction practices, such as "listening to what children have to say" (r=0.369; p=0.045) and "facing the child, making eye contact" (r=0.403; p=0.027), showed a significant correlation with developmental milestones; these were not fully achieved, especially in speech and mobility.

Conclusion: Parents value affective and interactive care despite the context of vulnerability. Health services should promote early stimulation and family involvement, fostering the comprehensive development of premature children.

Descriptors
Prematurity; Parents; Early Educational Intervention; Health Knowledge, Attitudes and Practice; Pediatric Nursing.

Resumo

Objetivo: Analisar a percepção dos pais sobre as crenças e práticas no cuidado de crianças nascidas prematuras, correlacionando-a com o marco de desenvolvimento infantil.

Método: Este estudo do tipo *survey* foi realizado com pais de crianças prematuras com até três anos de idade. Os dados foram coletados em instrumentos disponíveis na plataforma REDCap, incluindo questionário sociodemográfico, variáveis perinatais e neonatais, além da Escala de Crenças Parentais e Práticas de Cuidado (E-CPPC). Os dados foram analisados por estatística descritiva; para avaliar associações, foram usados os testes Qui-quadrado de Pearson ou exato de Fisher (nível de significância: 5%).

Resultados: Um total de 30 mães participaram, sendo que 46,6% das crianças nasceram prematuras extremas ou moderadas. As mães mostraram maior valorização de práticas voltadas ao bem-estar físico imediato (tais como manter as crianças limpas e evitar acidentes), em detrimento de estímulos cognitivos (tais como ler livros ou jogar com elas). Porém, práticas de interação direta, tais como "ouvir o que as crianças têm a dizer" (r=0,369; p=0,045) e "ficar de frente, olho no olho com as crianças" (r=0,403; p=0,027), apresentaram uma significativa correlação com os marcos do desenvolvimento; eles não foram plenamente atingidos, especialmente em fala e locomoção.

Conclusão: Os pais valorizam os cuidados afetivo e interativo apesar do contexto de vulnerabilidade. Os serviços de saúde devem promover a estimulação precoce e o envolvimento familiar, favorecendo o desenvolvimento integral das crianças prematuras.

Descritores
Prematuridade; Pais; Intervenção Educacional Precoce; Conhecimentos, Atitudes e Prática em Saúde; Enfermagem Pediátrica.

Resumen

Objetivo: Analizar la percepción de los padres sobre las creencias y prácticas en el cuidado de niños nacidos prematuros, correlacionándola con los hitos del desarrollo infantil.

Método: Este estudio de tipo encuesta fue realizado con padres de niños prematuros de hasta tres años de edad. Los datos fueron recolectados mediante instrumentos disponibles en la plataforma REDCap, incluyendo un cuestionario sociodemográfico, variables perinatales y neonatales, además de la Escala de Creencias Parentales y Prácticas de Cuidado (E-CPPC). Los datos fueron analizados mediante estadística descriptiva; para evaluar asociaciones se utilizaron la prueba de Chi-cuadrado de Pearson o la prueba exacta de Fisher (nivel de significación: 5%).

Descriptores
Prematuridad; Padres; Intervención Educativa Temprana; Conocimientos, Actitudes y Práctica en Salud; Enfermería Pediátrica.

How to cite:
Mós IF, Orsi KCSC, Nascimento LPP, Maia EBS, Balieiro MMFG. Parental perceptions of beliefs and care practices for children born prematurely. Rev Soc Bras Enferm Ped. 2025;25:eSOBEP202504i.

Data availability:
The study data are available in this article.

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Conflicts of interest: nothing to declare.
Submitted: December 15, 2025 | Accepted: December 19, 2025
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DOI: 10.31508/1676-3793202504i

Resultados: Participaron un total de 30 madres, y el 46,6% de los niños nacieron prematuros extremos o moderados. Las madres mostraron mayor valoración de prácticas orientadas al bienestar físico inmediato (como mantener a los niños limpios y prevenir accidentes), en detrimento de la estimulación cognitiva (como leer libros o jugar con ellos). Sin embargo, las prácticas de interacción directa, tales como "escuchar lo que los niños tienen que decir" (r=0,369; p=0,045) y "ponerse frente al niño, mirándolo a los ojos" (r=0,403; p=0,027), mostraron una correlación significativa con los hitos del desarrollo; estos no se alcanzaron plenamente, especialmente en el habla y la locomoción.
Conclusión: Los padres valoran el cuidado afectivo e interactivo a pesar del contexto de vulnerabilidad. Los servicios de salud deben promover la estimulación temprana y la participación familiar, favoreciendo el desarrollo integral de los niños prematuros.

Introduction

The birth of a child is a milestone for the family, representing a period of intense changes and adaptations in family roles and routines to meet newborns (NBs)' needs. When birth occurs prematurely, these demands become even more complex, unexpectedly altering family dynamics.[1]

Prematurity is an event that results from various unpredictable circumstances, regardless of location or social class, and is a global public health concern. In Brazil, approximately 340,000 premature babies are born each year, according to data from the World Health Organization (WHO).[2] Premature birth is one of the main factors associated with infant morbidity and mortality. It affects families and society with a social and financial cost that is difficult to measure, requiring intensive care during the neonatal period and clinical follow-up after hospital discharge.[3,4]

During intensive care, premature newborns (PTNBs) are exposed to stressful environments, including noise, frequent handling, bright light, and painful stimuli. These factors, combined with brain immaturity, impact their neurological and motor development, increasing the risk of cognitive deficits and developmental delays.[5,6] Therefore, early detection of these delays is essential to allow interventions during phases of greater brain plasticity.[7-9]

In this regard, the early stimulation approach aims to promote child development and well-being, preventing developmental delays and reducing existing disabilities, as well as contributing to structuring the mother-baby bond and the acceptance of these children by the family. Focusing on parental education and psychosocial support, this approach aims to improve the parent-child relationship and the environment in which a child develops.[7-9]

The benefits of early stimulation include improvements in neurological development, increased learning capacity, advances in motor and cognitive development, and a reduction in the risk of long-term emotional and behavioral problems. For early stimulation to be effective, parents and caregivers must actively engage in the process, following the guidance of specialized professionals and promoting activities that stimulate PTNBs' development at home.[8-11]

Parenting involves caring practices and beliefs that guide the interaction between parents and children.[5,6] The model proposed by Keller (2002; 2007) has a comprehensive approach, integrating biological and cultural aspects of these practices with a special focus on the first three years of life.[12,13]

This theoretical perspective allows us to understand how biological and sociocultural factors shape child development, as well as providing a basis for early interventions aimed at promoting health and the caregiver-child relationship.[14,15]

Understanding parental care practices can provide valuable insights for developing family-centered care strategies integrated into the local context, aiming to improve the health outcomes and quality of life of these children and their families. Including families in care settings from prenatal care to the hospitalization period of premature infants (PIs) can improve the approach to monitoring their growth and development. This can also help build health networks, with parents', families', and healthcare professionals' participation to promote early stimulation of PIs, thus reducing neonatal and infant morbidity.[3,4,6]

Therefore, the study aimed to analyze parents' perceptions of beliefs and practices regarding PI care, correlating them with children's typical developmental milestones.

Method

This survey-type study was developed with parents of PIs. The sample consisted of participants selected us-

ing non-probability snowball sampling, in which the first participants indicate new participants according to the inclusion criteria in the study. Parents were accessed via digital platforms or online parent groups.

The survey was disseminated through an invitation shared on Instagram® and Facebook® groups, with an explanatory text about the purpose of the study and a link for interested parties to access the questionnaire.

Parents or guardians of PIs under three years of age, over 18 years of age, and with internet access were included. Parents or guardians with communication difficulties or internet access issues were not included. Those who did not respond to the questionnaire within three days of signing the online Informed Consent Form (ICF) were excluded.

The ICF was applied and signed online by participants before accessing the research form.

To maintain study participants' anonymity, they were assigned a sequence of letters. Participants were assured of privacy and protection of their identity, as well as the freedom to refuse to participate or withdraw their consent without penalty at any stage of the research.

To determine the final sample, data were collected over six months. The questionnaire was administered online. Data were obtained through a form developed in REDCap® containing sociodemographic and perinatal variables, including a Parental Beliefs and Care Practices Scale (E-CPPC - *Escala de Crenças Parentais e Práticas de Cuidado*) in early childhood.[14]

REDCap® data were stored on a computer for the exclusive use of one of the researchers. The time required for participants to complete the questionnaire was 15-20 minutes.

The study was submitted to the Research Ethics Committee of the authors' affiliated institution, met the ethical and legal requirements, and was approved (Opinion 6,780,072; CAAE 77021223.1.0000.5505).

The variables in the study were as follows:

- Sample characterization variables: (1) related to parents: age (years), sex (female or male), education, profession, marital status, family income (minimum wages), social support; (2) related to the perinatal period: gestational age at birth (weeks), type of childbirth, place of childbirth, complications experienced, number of living children; and (3) related to PIs: chronological age at the time of application of the form, length of hospital stay, complications at birth and during hospitalization.
- Care practice variables: E-CPPC in early childhood aimed to assess the frequency of behaviors and the degree of importance attributed to these practices. It was composed of two domains: practices performed by mothers and importance attributed to these practices, totaling 18 items related to themes such as primary care, physical contact, physical stimulation, object stimulation, and face-to-face contact. These items were as follows: Helping when crying; Feeding; Keeping clean; Ensuring sleep and rest; Not letting them be too hot or too cold; Holding them; Always having them nearby; Trying to prevent accidents (safety precautions); Letting them run, swim, climb freely; Doing physical activities; Playing games; Hanging toys on the crib; Reading books together; Showing them interesting things; Explaining things; Listening to what they have to say; Answering questions; and Facing children making eye contact. The scale was assessed regarding the frequency of performing the practices according to a five-point Likert scale, ranging from one (never) to five (always). Regarding the importance of the practices, a 5-point Likert scale ranged from 1 (not very important) to 5 (very important).
- Child development current stage variables: to assess child development, the typical milestones established in the Child Health Booklet were used as a reference.[16] The assessment was structured according to the children's age (in months), allowing the caregiver to identify whether the skills corresponding to the current age range are being acquired and whether the developmental milestones expected for previous ages have already been achieved. Family members will indicate whether milestones are present or absent. In the comprehensive assessment of children's development, categories were categorized as probable developmental delay, alert, and adequate development.

After collection, data were exported to REDCap® spreadsheets and analyzed using R Core Team software (v. 4.4.0) using descriptive statistics according to

their nature: through absolute and relative frequencies (if qualitative) or through mean, median, minimum, maximum, standard deviation, first quartile and third quartile (if quantitative).

Beliefs and the importance of beliefs were treated as ordinal variables. The Kruskal-Wallis test was used when a variable did not follow normality to compare the Likert scale of beliefs in the different developmental classifications and the importance scale. The ANOVA test was applied when normality and homoscedasticity of variances were present. If the groups formed were smaller (when there were two groups), Student's t-test was used if the variable followed normality in both groups; otherwise, the Mann-Whitney test was used. When there was normality but not homoscedasticity of variances, the Games-Howell test was used. The significance level adopted was 5% for all tests.

Results

Thirty parents and/or guardians of PIs and women participated in the study (mean age: 29.03 ± 5.91 years). Table 1 shows participants' sociodemographic data. Most of them resided in the state of São Paulo (86.7%). In relation to education, they had completed high school (36.7%) and higher education (36.7%). More than half of the families had an income between one and two minimum wages (53.3%), and reported receiving support in childcare (73.3%), predominantly from family (95.5%).

Table 2 shows data related to the prenatal, childbirth, and postnatal history of PIs, according to information reported by the participating mothers. The mean number of pregnancies was 2.17 (±1.53) and prenatal visits was 8.17 (±4.79). Gestational complications occurred in 70% of participants, mainly pregnancy-specific hypertensive disease, placental abruption, and urinary tract infection. Most deliveries occurred in public hospitals (via cesarean section). The mean gestational age was 32.5 weeks, with extremely premature (24-30 weeks; 26.7%), moderately premature (31-35 weeks; 46.6%), and borderline premature (36-37 weeks; 26.7%). The mean neonatal hospital stay was 59 days, with complications in 60% of cases.

The care practices most frequently mentioned as "always performed" were the following: feeding (100%), ensuring sleep and rest (100%), keeping the child clean (93.3%), preventing accidents (93.3%), and responding to crying (96.7%). Physical and visual contact was valued, with mentions of holding the child in their arms (83.3%) and maintaining eye contact (86.7%). In contrast, cognitive stimulation practices, such as "Reading books together" (13.3%) and "Playing games" (20%), were less frequently cited (Table 3).

Regarding beliefs, physical care practices, and safety, feeding (96.7%), ensuring sleep and rest (96.7%), and preventing accidents (96.7%) were considered "very important" by almost all mothers. Aspects related to interaction and cognitive stimulation were also valued, highlighting "Listening to what children have to say" (86.7%), "Explaining things" (83.3%), and "Showing interesting things" (63.3%) (Table 3).

The developmental assessment indicated that children had adequate development (30%), were alert (26.7%), and presented a probable delay (30%), mainly in speech and locomotion skills, being more prevalent among PIs with a gestational age <34 weeks.

Table 1. Participant sociodemographic profile (n=30)

Variables	n(%)
Country region	
Central-West	2(6.6)
Southeast	27(90.0)
South	1(3.4)
Education level	
Complete elementary school	1(3.3)
Incomplete high school	1(3.3)
Complete high school	11(36.7)
Incomplete higher education	6(20.0)
Complete higher education	11(36.7)
Occupation	
Unemployed and/or unemployed	22(73.3)
Employed	8(26.7)
Family income (minimum wage)	
<1	2(6.7)
1-2	16(53.3)
2-3	5(16.7)
3-4	3(10.0)
>4	4(13.3)
Marital status	
Married	19(63.3)
Single	8(36.7)
Child care support	
Yes	22(73.3)
No	8(26.7)
Type of support	
Family	21(95.5)
Professional support	1(4.5)

Table 2. Perinatal characteristics of premature infants of study participants (n=30)

Period	Variable	Mean (SD)	Median (Min.-Max.)	n(%)
PRENATAL	Number of pregnancies	2.17(1.53)	2.00(1-8)	-
	History of abortion			
	Yes	-	-	6(20.0)
	No	-	-	80(24.0)
	Number of abortions	1.5(0.83)	1.00(1-3)	-
	Prenatal consultation			
	Yes	-	-	30(100.0)
	No	-	-	0(0.0)
	Number of appointments	8.17(4.79)	7.00(1-20)	-
	Gestational complications			
	Yes	-	-	21(70.0)
	No	-	-	9(30.0)
	Types of complications			
	Pregnancy-induced hypertension	-	-	8(38.1)
	Placental abruption	-	-	3(14.3)
	Urinary tract infection	-	-	3(14.3)
	Twin pregnancy loss	-	-	3(14.3)
	Gestational diabetes	-	-	2(9.5)
	Polyhydramnios	-	-	1(4.8)
	High-risk pregnancy	-	-	1(4.8)
BIRTH	Gestational age (weeks)	32.53(3.55)	34(25-36)	-
	Prematurity classification (weeks)			
	Extreme (24-30)	-	-	8(26.7)
	Moderate (31-35)	-	-	14(46.6)
	Borderline (36-37)	-	-	8(26.7)
	Place of delivery			
	Public hospitals	-	-	22(73.3)
	Private hospitals	-	-	8(26.7)
	Type of delivery			
	Cesarean	-	-	19(63.3)
	Vaginal	-	-	11(36.7)
	Complications during delivery			
	Yes	-	-	10(33.3)
	No	-	-	20(66.7)
	Types of complications			
	Hemorrhage	-	-	4(40.0)
	Hypertension	-	-	2(20.0)
	Others	-	-	5(50.0)
	Complications at birth			
	Yes	-	-	18(60.0)
	No	-	-	12(40.0)
POSTNATAL	Neonatal hospitalization			
	Yes	-	-	24(80.0)
	No	-	-	6(20.0)
	Length of hospital stay (days)	61.86(50.67)	45(5-131)	-
	Corrected age (days)	584.69(483.14)	454(18-1466)	-

SD: standard deviation.

Correlation analyses indicated positive associations between some practices related to childcare and maternal variables. It was observed that a greater number of prenatal visits was associated with a higher occurrence of the practice of hanging toys on the crib (r=0.439; p=0.019). Likewise, greater gestational age was related to both the practice of hanging toys on the crib (r=0.432; p=0.022) and playing games with children (r=0.414; p=0.028) so that a greater number of visits and greater gestational age were related to a higher occurrence of these practices.

It was also found that women with a higher number of pregnancies had a higher frequency of engag-

Table 3. Distribution of items in the Parental Beliefs and Care Practices Scale (E-CPPC - *Escala de Crenças Parentais e Práticas de Cuidado*) according to frequency and importance of childcare practices (n=30)

E-CPPC items	Frequency of childcare practices	N (%)	Importance reported by parents	N (%)
Hanging toys on the crib (*Pendurar brinquedos no berço*)	N	2(6.6)	LI	1(3.3)
	R	1(3.3)	+-I	6(20.0)
	ST	6(20.0)	RI	2(6.7)
	AA	5(16.7)	I	9(30.0)
	A	16(53.4)	VI	12(40.0)
Keep children clean (*Manter as crianças limpas*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	2(6.7)	I	3(10.0)
	A	28(93.3)	VI	27(90.0)
Playing games (*Jogar jogos*)	N	7(23.3)	LI	3(10.0)
	R	5(16.7)	+-I	3(10.0)
	ST	6(20.0)	RI	3(10.0)
	AA	6(20.0)	I	6(20.0)
	A	6(20.0)	VI	15(50.0)
Trying to prevent them from having accidents (*Tentar evitar que elas se acidentem*)	N	1(3.3)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	1(3.3)	I	1(3.3)
	A	28(93.4)	VI	29(96.7)
Making sure they sleep and rest (*Cuidar para que elas durmam e descansem*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	0(0.0)	I	1(3.3)
	A	30(100)	VI	29(96.7)
Explaining things (*Explicar coisas*)	N	1(3.3)	LI	0(0.0)
	R	3(10.0)	+-I	1(3.3)
	ST	2(6.7)	RI	0(0.0)
	AA	4(13.4)	I	4(13.4)
	A	20(66.6)	VI	25(83.3)
Holding them in the lap (*Carregá-las no colo*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	3(10.0)
	ST	1(3.3)	RI	0(0.0)
	AA	4(13.4)	I	7(23.3)
	A	25(83.3)	VI	20(66.7)
Reading books together (*Ver livrinho juntos*)	N	5(16.7)	LI	1(3.3)
	R	6(20.0)	+-I	1(3.3)
	ST	6(20.0)	RI	1(3.3)
	AA	9(30.0)	I	11(36.7)
	A	4(13.3)	VI	16(53.4)
Answering questions asked by children (*Responder perguntas feitas pelas crianças*)	N	10(33.3)	LI	1(3.3)
	R	3(10.0)	+-I	0(0.0)
	ST	2(6.7)	RI	0(0.0)
	AA	3(10.0)	I	7(23.3)
	A	12(40.0)	VI	22(73.4)
Feeding children (*Alimentar as crianças*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	0(0.0)	I	1(3.3)
	A	30(100.0)	VI	29(96.7)
Always having children nearby (*Ter as crianças sempre perto*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	0(0.0)	I	1(3.3)
	A	30(100.0)	VI	29(96.7)
Letting children be free to run, swim, climb (*Deixar as crianças livres para correr, nadar, trepar*)	N	7(23.3)	LI	1(3.3)
	R	2(6.7)	+-I	3(10.0)
	ST	4(13.3)	RI	0(0.0)
	AA	6(20.0)	I	8(26.7)
	A	11(36.7)	VI	18(60.0)
Doing physical activities with children (*Fazer atividades físicas com as crianças*)	N	7(23.3)	LI	1(3.3)
	R	2(6.7)	+-I	3(10.0)
	ST	5(16.7)	RI	0(0.0)
	AA	9(30.0)	I	6(20.0)
	A	7(23.3)	VI	20(66.7)
Helping children when they are crying (*Socorrer as crianças quando estão chorando*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	1(3.3)
	ST	0(0.0)	RI	0(0.0)
	AA	1(3.3)	I	2(6.7)
	A	29(96.7)	VI	27(90.0)
Showing children interesting things (*Mostrar coisas interessantes às crianças*)	N	1(3.3)	LI	0(0.0)
	R	2(6.7)	+-I	1(3.3)
	ST	2(6.7)	RI	0(0.0)
	AA	7(23.3)	I	10(33.3)
	A	18(60.0)	VI	19(63.4)
Not letting children be too cold/ hot (*Não deixar que as crianças passem frio/calor*)	N	1(3.3)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	0(0.0)	RI	0(0.0)
	AA	0(0.0)	I	1(3.3)
	A	29(96.7)	VI	29(96.7)
Listening to what children have to say (*Ouvir o que as crianças têm a dizer*)	N	5(16.7)	LI	1(3.3)
	R	1(3.3)	+-I	0(0.0)
	ST	1(3.3)	RI	0(0.0)
	AA	3(10.0)	I	3(10.0)
	A	20(66.7)	VI	26(86.7)
Facing children making eye contact (*Ficar frente a frente, olho no olho*)	N	0(0.0)	LI	0(0.0)
	R	0(0.0)	+-I	0(0.0)
	ST	1(3.3)	RI	0(0.0)
	AA	3(10.0)	I	4(13.3)
	A	26(86.7)	VI	26(86.7)

N: never; R: rarely; ST: sometimes; AA: almost always; A: always; LI: little important; +-I: more or less important; RI: reasonably important; I: important; VI: very important.

ing in physical activities with their children (r=0.574; p=0.001), as did those with a higher number of living children (r=0.645; p<0.001).

Concerning maternal characteristics, it was found that older maternal age was associated with a greater emphasis on children's safety (r=0.429; p=0.023). Furthermore, a longer gestational age was associated with greater encouragement of children's freedom to run and play (r=0.395; p=0.037).

In summary, participants demonstrated an understanding of the importance of affective and interactive care, although cognitive stimulation practices were less frequent in their routines.

The emphasis on direct interaction and physical stimulation suggests a potential for strengthening educational strategies that broaden the repertoire of care aimed at the overall development of PIs.

Discussion

This study analyzed the perceptions of parents and/or guardians (represented exclusively by mothers) regarding their beliefs and practices in caring for PIs. The exclusively female composition of the sample reflects the role historically assigned to women as primary caregivers of children, especially in contexts of social and economic vulnerability. This cultural aspect, which is widely described in the literature, reinforces the maternal centrality in childcare; this may have influenced the profile of respondents and the predominant perspective in reported practices.[17,18]

Most participants had low levels of education and family income of 1-2 minimum wages, in addition to significant unemployment rates. The majority of these births occurred in public hospitals and involved extremely or moderately PIs. This set of characteristics highlights participants' socioeconomic vulnerability, a condition that can directly impact how mothers perceive and perform childcare. Studies indicate that the level of education and economic stability of caregivers are determining factors for access to information, resources, and broader care practices, influencing the overall development of children.[18]

The practices most valued by mothers were associated with basic needs and physical protection of children, such as "Keeping children clean", "Feeding", and "Preventing accidents". This emphasis points to care focused on survival and maintaining physical integrity, which is understandable given social vulnerability and a history of prematurity. In situations where access to resources is limited and experiences with neonatal illness are significant, caregivers tend to prioritize immediate protective and comforting practices over actions aimed at cognitive stimulation.[19]

The experience of neonatal hospitalization, which was experienced by 80% of children in the sample, may have reinforced this perception of protective care. Prematurity accentuates the maternal need to ensure babies' safety and physical well-being after discharge when associated with early exposure to hospital environments and invasive procedures. Thus, practices such as "Helping children when they cry" and "Making sure they sleep and rest" take on symbolic and affective values that go beyond basic care, also representing an attempt to compensate for the period of separation imposed by hospitalization.[20,21]

On the other hand, practices associated with cognitive stimulation and symbolic development, such as "Reading books together" and "Playing games", were less frequent. This trend, as observed in studies with similar populations, is related to less available time, domestic overload, and a lack of specific guidance from healthcare services.[22,23] However, the literature highlights that simple interactive activities (such as reading, playing, and dialogue) have a significant impact on the cognitive, linguistic, and socio-emotional development of children, especially in the early years of life.[24,25]

Despite the observed limitations, mothers demonstrated an understanding of the importance of emotional bonding and direct interaction with their children. The practices of "Listening to what children have to say" and "Facing children making eye contact" showed positive and statistically significant correlations; this indicates that the greater the belief in the importance of these actions, the more frequent they are in the care routine. These results are consistent with the literature and highlight the value placed on the affective and communicational dimensions of care, which are fundamental for establishing secure attachments and healthy emotional development.[23,26]

Findings on typical developmental milestones showed that a portion of the children presented delays or warning signs, especially in skills related to speech, locomotion, and autonomy. These results agree with studies that pointed to a higher risk of neuropsychomotor delay among PIs due to neurological immaturity, length of hospital stay, and neonatal complications. Thus, longitudinal follow-up and early interventions are indispensable strategies to reduce the impacts of prematurity on child development.[27]

In general, coherence was observed between maternal beliefs and practices. Participants demonstrated an understanding that care is not limited to the biological dimension, also involving interaction, affection, and communication. Even in the face of adverse conditions, the mothers sought to integrate practices that favor children's overall development, albeit intuitively.[28]

These results reinforce the importance of public policies and intersectoral actions aimed at strengthening the families of PIs. Systematic monitoring by multidisciplinary teams can broaden their repertoire of care practices, promote family autonomy, and foster children's overall development when combined with parental education and early stimulation programs.[29] The active involvement of the family in the care process (from neonatal hospitalization to outpatient follow-up) is essential to ensure continuity of care and maximize outcomes for children's health and well-being.[30]

Thus, the present study showed that the participating mothers recognize and value the role of affective care; they demonstrated a willingness to engage in practices that stimulate interaction and bonding with their children, despite being marked by social vulnerability. This finding reinforces the need to strengthen support for families as the structuring axis of care for PIs, integrating physical, emotional, and cognitive aspects in a truly family-centered approach.

This study had limitations that should be considered when interpreting the results. The use of non-probability (snowball) sampling may have introduced selection bias, as participants were recruited through contact networks. This limits the generalizability of the findings to the population of parents of PIs. Furthermore, online data collection may have restricted the participation of parents with limited access to or familiarity with digital technologies.

Despite these limitations, the findings contributed to a better understanding of parental beliefs and practices in PI care, especially in the context of healthcare and nursing practice.

Conclusion

Practices related to physical health, such as keeping children clean and preventing accidents, are highly valued by mothers. Activities focused on cognitive development, such as reading books and playing games with children, are less valued. It is observed that several milestones in motor, cognitive, and independence development are not achieved. Practices involving direct interaction, such as listening to the child and maintaining eye contact during communication, are associated with child development.

Contributions

Mós IF, Orsi KCSC, Nascimento LPP, Maia EBS, and Balieiro MMFG declare that they contributed to study conception. Mós IF, Orsi KCSC, and Balieiro MMFG declare that they contributed to data collection. Mós IF, Orsi KCSC, Nascimento LPP, Maia EBS, and Balieiro MMFG declare that they contributed to data analysis and interpretation. Mós IF, Orsi KCSC, Nascimento LPP, Maia EBS, and Balieiro MMFG declare that they contributed to article writing and/or critical review. Mós IF, Orsi KCSC, Nascimento LPP, Maia EBS, and Balieiro MMFG declare that they approved the final version to be published.

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