Original Article

Self-care practices related to children nutrition in rural areas

Práticas de autoatenção relativas à alimentação de crianças do meio rural

Prácticas de autoatención relacionadas a la alimentación de niños del medio rural

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ABSTRACT

Objective: describe the self-care practices related to children nutrition in rural areas and its interactions with models of health care.
Methods: qualitative study, descriptive, developed in rural communities of Rio Grande do Sul State, Brazil, with seven families, and an amount of ten women. For data production, we used observation and open interviews. We analyzed data according to Leininger's thematic analysis.
Results: "Human milk is good, but it is not enough" and "my family have influenced my decisions: I could breastfeed" are the main themes in the study. From them, we notice the necessity of comprehending the symbolical meanings of these practices for children's health production with culturally congruent and effective actions.
Conclusions: Mixed breastfeeding seems to be the most important self-care practice related to children nutrition in the analyzed rural areas. These practices are among the knowledge of the Hegemonic Medical Model for health education and practice and knowledge learned from the family and community.
Keywords: Breastfeeding. Culture. Nursing. Rural population.

RESUMO

Objetivo: descrever as práticas de autoatenção relacionadas à alimentação de crianças do meio rural e suas interações com os modelos de atenção à saúde.
Métodos: estudo qualitativo, descritivo, realizado em comunidades rurais do interior do Rio Grande do Sul, Brasil, com sete famílias, totalizando dez mulheres. Na produção dos dados utilizaram-se a observação e entrevistas abertas. Analisaram-se os dados por meio da análise temática de Leininger.
Resultados: "O leite materno é bom, mas não basta" e "Minha família influenciou nas minhas decisões: eu consegui amamentar" são os temas emergentes no estudo. Dos temas emerge a necessidade de compreensão dos significados simbólicos dessas práticas para a produção de saúde das crianças, mediante ações culturalmente congruentes e eficazes.
Conclusões: O aleitamento materno misto destaca-se dentre as práticas de autoatenção relativas à alimentação da criança do meio rural. Essas práticas transitam entre os conhecimentos do Modelo Médico Hegemônico e dos familiares e comunidade.
Palavras-chave: Aleitamento materno. Cultura. Enfermagem. População rural.

RESUMEN

Objetivo: describir las prácticas de autoatención relacionadas a la alimentación de niños del medio rural y sus interacciones con los modelos de atención a la salud.
Métodos: estudio cualitativo, del tipo descriptivo, realizado en comunidades rurales del interior del estado del Rio Grande do Sul, Brasil, con siete familias, totalizando diez mujeres. Se utilizó la observación y encuestas abiertas. Los datos fueron analizados por medio del método del análisis temático de Leininger.
Resultados: "La leche materna es buena, pero no suficiente" y "mi familia influenció en mis decisiones: yo conseguí amamantar" son los temas de este estudio. De los temas emerge la necesidad de comprensión de los significados simbólicos de esas prácticas para la producción de salud de los niños mediante acciones culturalmente congruentes y eficaces.
Conclusiones: La lactancia materna mixta se destaca entre las prácticas relacionadas a la alimentación de los niños del medio rural. Estas prácticas transitan entre los conocimientos del Modelo Medico Hegemónico y de los familiares y comunidad.
Palabras clave: Lactancia materna. Cultura. Enfermería. Población rural.

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INTRODUCTION

The theme of this study is the nutrition of children in early childhood living in rural areas, reason for which the expression child is used in this article, encompassing infants (children under one year of age) and children in early childhood (one to three years of age)[1].

The benefits of breastfeeding (BF) for the child, mother, the family and society are anchored on scientific evidence[2]. Therefore, the World Health Organization (WHO) recommends that infants be exclusively breastfed for the first six months of life. After that, the gradual inclusion of food with the maintenance of BF until at least two years of age is recommended because of nutritional requirements[1].

Moreover, it is emphasized that the act of feeding a child is influenced by multidimensional factors: biological, social, cultural. From the social point of view, some elements are favorable to BF, among which family support, especially from the child's grandmother, appropriate conditions in the workplace and positive previous breastfeeding experience by the women themselves and/or female family members[3]. On the other hand, early motherhood, limited years of maternal education and the need to work outside the home are factors that contribute to early weaning[4].

A study that compares the nutrition of infants in Brazilian capitals reveals different practices according to the analyzed region. In the southern region, the consumption of warm tea prevails in children up to six months, which is associated with the cold weather. In the northeast and southeast, the consumption of juices and of milk formulas prevail. The consumption of juices is associated to the warm climate and abundance of tropical fruits in the northeast. In the southeast, the introduction of juices and other types of milk is associated with the purchasing power of households[5].

The family context mediates decisions about feeding a child, as each woman, her family and community have unique values, knowledge and practices laden with symbolism that guides them on this subject. An international study reports that behaviors related to exclusive breastfeeding are shaped by cultural, social and religious influences, being introduced to women by family, close social network and religious community[6].

In this logic, understanding this complexity includes, among other possibilities, the cultural perspective, stressing that culture is understood here as a network of symbols whose meanings guide people's decisions and that of their social groups on the different issues that involve life, among them, those related to feeding children. A symbol is "any object, act, knowledge, quality or relationship that serves as a link to a concept – the concept is the symbol's 'meaning'"[7:67]. Thus, it is understood that the knowledge of the people and experts – among which are professionals linked to the Hegemonic Medical Model – comprise the culture and, therefore, it can be defined as a "*model of*" and "*model for*"[7] the production of self-attention practices involving child nutrition.

Self-attention practices are meanings and practices used on an individual and/or social group level, to address the processes that affect health, whether in real or imaginary terms, without the direct and intentional intervention of experts, even when they can be the reference for these activities[8].

In addition to this set of concepts that justify the interest of a group of nurses in the production of a study whose **purpose** is self-attention practices in the nutrition of children living in rural areas, it is noteworthy that the rural context, in which the authors of this publication are professionally inserted, differs from the urban environment. This distinction is associated with the shortage and poor access to services in rural areas – including health services – the smaller social support network for nursing mothers, because of the geographical distance between the families, the type of bond between the nursing mother and members of the network and the sociocultural factors that justify decisions made on the nutrition of a child[9-10].

Emphasis should be made on the fact that in a search performed in the Virtual Health Library, focused on feeding infants who live in rural areas, and that accessed original *online* articles published from 2004 to 2013, focused on the Latin American reality (main study scenario of the self-attention model's author, and the theoretical framework adopted in this research), eight publications were obtained. It found no investigations that spoke exclusively of Rio Grande do Sul, and a lack of research with cultural approach, especially using the theoretical framework of self-attention[8].

Given the problems presented and the interest of the authors explained here, the **aim** of this study is to "describe self-attention practices related to the nutrition of rural children and their interactions with the health care models."

In view of this goal, choice was made for theoretical reference focused on self-attention practices[8,11]. In this framework, considering the existence of social groups in Latin America that are stratified/differentiated through their working conditions, economic status, ethnicity, religion, it is known that the subjects and their groups use some forms of attention to cope with their troubles, where interaction between two or more is common. This process

results from the initiative of one of these modes of attention, such as the biomedical sector, when it associates its therapeutic alternative to self-attention groups, and can also be the result of the subject and/or social group itself when searching for another alternative to their troubles, which characterizes self-attention practices[8].

METHODOLOGY

This is a descriptive, qualitative study[12] and, because of the theoretical framework adopted, it has a cultural perspective, approaching an ethnographic study[13]. The general scenario is a small town in the Northwest part of Rio Grande do Sul state, where 57.1% of the population reside in rural areas. Of the inhabitants, 321 are children between zero and four years old[14]. The scenario focused on consists of two rural communities – Linha Aparecida and Linha Boqueirão (fictitious names).

When traveling by foot from one residence to another, crossing dirt roads, it was observed that the scenario is made up of properties ranging from farms, with a main house that stands on medium sized land lots and produce mate herb, wheat and other agricultural products, to residences with houses made of either wood as masonry. Of these, some have several animals and others only a cow and some chickens.

Linha Aparecida is located about three kilometers from the city, which makes it easier for most men to work in urban areas. Some women also work in the city, but most remain at home, involved with the rural routine, which requires care to the children and husband, preparing meals (which are made on the wood stove and start early in the morning), caring for animals, milking the cows, growing food in the garden and carrying out other household chores.

Linha Boqueirão is located about 12 kilometers from the city, but significantly resembles Linha Aparecida, but with more difficult access to the county's head offices and with most people working in their own locality. As for the health care organization, Linha Aparecida has the physical and human structure of a Family Health Strategy (FHS) and Linha Boqueirão, despite not having the physical structure, has a rural FHS team that, every fortnight, serves the community in a room at the local school.

Both communities have a village with a school, churches, a commercial "supermarket" type establishment and a cluster of households where retirees and urban workers reside. Families living in places where you can not see the neighboring house earn their income from agriculture. Despite this distance, all residents know each other and commonly visit. It is also common for one of the married children to live on land that is adjacent to that of their parents, which facilitates the involvement of the grandmother in the care of grandchildren.

The inclusion criteria of the participants in this study were: women over 18 years of age with child(ren) between one month and three full years of age and residing in one of the two rural communities listed for the study. In an attempt to achieve greater clarity about the study setting allowed by the observations, it was decided to include, in addition to mothers, grandmothers caring for children whose mothers work outside the home. The choice for families with children between zero and three years old assumed that the respondents would easily describe the self-attention practices adopted in the children's feeding process, as they could possibly know the experiences on the theme by memory. Thus, the study included seven families, a total of ten key respondents, which were well defined during the data collection process and not previously[13]. Key respondents are people who wish to participate in the study and master the subject investigated[15]. Exclusion criteria, women with impaired cognitive ability.

The first contact with families to invite them to participate in the study came after the visitors of the Better Early Childhood Program (PIM) had raised the interest of those that fitted the inclusion criteria. This contact took place at home, in the company of the PIM visitor, when the objectives and methodology of the study were made clear and the possibility of further visits to start the data collection was verified.

In data collection (May-August 2015), the non-participant observation and interview technique were used. Seeking a deeper understanding of the communities and the daily lives of families, the researcher sought to alternate the days of the week during which they lived with families, in addition to using shifts, privileging lunch time, and morning and afternoon snack times. Each family was visited at least four times, for three to four hours, totaling about 100 hours in the field. The observations were intended to unite the cultural context with the object of study, since the representations do not always correspond to the experience, which indicates the need for observation[11]. General activities carried out by family components were observed, especially the feeding practices of children. On the last visit, an interview was held in an attempt to collect general data and the socio-demographic profile of the subject's daily life. Then, focus was placed on the following question: "Tell me, how you have fed your child since birth until now?"

In the analytical process, observations were recorded in a field diary and the interviews, that were audio-recorded

and also transcribed to the diary, were submitted to the thematic analysis proposed by Leininger: 1) collection and description of the raw data in which the information from data collection techniques were recorded, seeking to preliminarily identify the symbols and contextual meanings related to the study area from the internal constructs of the group's culture and the theoretical framework adopted; 2) identification of descriptors and components, from similarities and differences between the information obtained and their meanings; 3) contextual analysis and recurring patterns when the data for saturated ideas and recurring patterns of meaning, similar or different, were examined, focusing on expressions, structural forms or explanations related to the research, validating the data with respondents; 4) identification of relevant topics, which corresponds to the highest stage of the analysis[13].

The validation of the results was done by confirmability, during the researcher's meetings with the respondents, which happened held at least four times. This took place to reaffirm what was heard, seen or experienced in relation to the phenomena under study[13], giving the interpretations operated in this intercourse, corresponding to "micro-validations". Furthermore, the final research report was read by three respondents, seeking the final validation of findings.

The research project was approved by Opinion 1,060,826, issued by the Ethics Committee of the Federal University of Santa Maria/Rio Grande do Sul and the data collection process and information safeguarding obeyed Resolution 466/2012[16]. All respondents signed the Free and Informed Consent Form. To preserve the anonymity of respondents, they are identified in the text as follows: F1 (Family) – mother 1 – David, 2 years and 4 months. Institutions and people's names were replaced by codenames, preserving only the age of the child, which seemed necessary due to the peculiarities regarding the feeding habits of each age group.

RESULTS

Of the seven families participating in this study, three reside in Linha Aparecida and four in Linha Boqueirão. Eight respondents are mothers and two grandmothers. It is noteworthy that one of the mothers, codified in this section as mother/grandmother 05 and with 36 years of age, plays the role of mother and grandmother, taking care of her son and grandson simultaneously while her daughter works outside the home.

Regarding age, at the time of the study, the mothers were on average 28 years old, and the grandmothers 56 years old (excluding the mother/grandmother, recorded among mothers). Regarding education, four have not finished elementary school, among the grandmothers, one has completed elementary school, one has not completed high school, three have completed high school and one has a college degree. As for the marital status of mothers, three are married, four are in a common-law marriage and one is single and lives with her parents; the grandparents are married. The mothers' offspring ranges from one to five, with an average of two children per woman. Concerning the work, two mothers work outside the home – one in the urban and another in the rural setting; the other participants are involved with the farm work routine. Of the seven families, four are involved in milk production, two sell the product and two produce for domestic consumption. The others have easy access to the product by visiting family members and/or neighbors. Among the mothers, two no longer breastfed their children during the data collection, and the weaning occurred at seven months and a year and half, respectively. Six had children who were being breastfed, three of them had children under two years of age and three had children over three years of age.

During the review process, six cultural patterns have given rise to two themes, from the descriptors selected by similarity of meaning and sense, presented here:

Theme 1: Breast milk is good, but not enough!

Mixed breastfeeding (MBF) at birth or at any time before the sixth month of life is the focus of this theme that emerges from four synthesizing cultural patterns of the reasons that modulate this practice: *"I had little milk"; "My milk did not come down because of the cesarean section anesthesia"; "I didn't have a nipple"* and *"My baby was small, weak, had health problems."*

The respondents identify breast milk as the most suitable food for an infant, symbolizing health as it prevents disease, for constituting a symbol that is associated with the saving money and for the practicality represented by the absence of concerns over milk preparation, transportation and maintenance, which facilitates moments of leisure and because it protects the parents from the rigor of winter nights.

> *Breast milk prevents a lot of diseases, it's healthier for children (F 05 – mother 06 – Arthur 11 months).*

> *They say that breast milk is healthier (F 04 – mother 04 – Lucas – 2 years and 10 months).*

> *It's good because we don't have to buy it (giggles). Imagine if you had to buy XXX [specific powdered milk for infants]*

that doctors prescribe. It's about 50 reais a can. Thank God I never needed it: 'where would I get the money?' Breast milk is cheaper (F 05 – mother/grandmother 05 – Larissa 3 years and 2 months).

It makes it easier because you don't have to carry the milk, a bottle and stuff around. When we go out he is breastfed exclusively (F 03 – mother 03 – Cauã 1 year and 1 month).

As long as I have milk I will continue to breastfeed, especially now in the winter, because it is more practical. We don't catch any colds! " (F 05 – mother/grandmother 05 – Larissa 3 years and 2 months).

This recognition is also based on an interpretation that transcends nutritional issues, when they interpret that, by breastfeeding, they meet the emotional needs of the child, as noted in the study scene.

That cry is because the baby's sleepy. 'Come to mommy!' [The child lay on the respondent's lap, breastfed a bit and left to play. The child soon went back to breastfeeding, as little as the first time]. Before he starting eating other foods, he drank much more breast milk. Now, sometimes he only wants breast milk when he wants to sleep (F 03 – mother 03 – Cauã 1 year and 1 month).

Breastfeeding is love. An exchange. You saw it, he cried and came over to be breastfed but he wasn't hungry, he wanted affection! Breast feeding is more than providing food, it's for when he feels in trouble or something goes wrong. He tried to open the door and couldn't, so he came over and wanted breast milk. It's a security, an affection (F07 – mother 08 – Miguel 2 years and 7 months).

At the same time, it serves affective needs, life requires care to the child's physical size also be undertaken. In this perspective, the practice of breastfeeding assumes a role of facilitating care that is often rejected by the child, as was observed when one of them lay down on the mother's lap and in the drowsiness of breastfeeding, the respondent took the opportunity to cut the child's nails:

It's the only way to cut her nails! (F 05 – mother/grandmother 05 – Larissa 3 years and 2 months).

The identification of breast milk attributes and benefits constitutes a symbol whose meaning guides the decision to breastfeed as the first option for child feeding. However, this is not enough to decide in favor of exclusive breastfeeding, which contributes to MBF, being a prevalent self-attention practice among the studied families from before the sixth month of life and which extends beyond two years of age.

The interpretation that they produce little milk and that the child has difficulty sucking the breast also contributes to this practice. Insufficient milk production is interpreted as a natural feature for some women due to family characteristics, or is associated with a circumstantial experience. The finding of this insufficiency occurs as the child is not satisfied with breast milk alone, which is validated by the family and by health professionals.

Breast milk is better! But, I ended up giving her breast milk, XXX and cow milk, because my milk isn't enough. I give her breast milk but she doesn't stop crying. So, the doctor said to give her XXX, because I don't have enough milk (F6 – mother 07 – Milena 2 months).

I had difficulties breastfeeding my children. Of the four, I only managed to breastfeed one. I didn't have enough milk, my breasts dried out (F6 – grandmother 03 – Milena 2 months).

When he was two months old, I went back to school. While I was in school, he was with his father, who gave him XXX. By the end of classes, he was drinking cow milk and then I continued breastfeeding. I didn't produce enough milk, so I couldn't leave my milk for him. I ended up giving him both kinds (F3 – Mother 03 – Cauã – 1 year and 1 month).

Insufficient milk production is also associated to the anesthesia used in cesarean sections, which is almost always bypassed by supplementing the child's nutrition with other types of milk and by the mother using medication.

My milk didn't come down because of the anesthesia [...]. They gave me XXX at the hospital. At home, I took the medicine the doctor gave me and my milk came down (F6 – mother 07 – Milena 2 months).

When he was born, I had no milk because of the anesthesia. At the hospital, they gave him XXX in a syringe or cup (F4 – mother 04 – Lucas – 2 years and 10 months).

In an isolated case, the nipple shape is associated with breastfeeding difficulties soon after birth.

I didn't have a nipple and the nurses had a lot of trouble getting him to breastfeed. He wasn't breastfed at the hos-

pital. So, I gave him the XXX they gave him at the hospital (F3 – mother 3 – Cauã – 1 year and 1 month).

Children with complications or some perinatal illness, especially, symbolize a very fragile being that is too weak to be breastfed, which also guides the practice of MBF.

He had difficulty breastfeeding because of the problems he had when he was born. He was in the incubator, he had a probe for food and was on oxygen. He was still very small and weak when he came home, and had no strength to suck (F3 – mother 3 – Cauã 1 year and 1 month).

He didn't want the breast because he was born so small. He also had reflux(gastroesophageal). I had to be careful with what was offered (F4 – mother 04 – Luke 2 years and 10 months).

The complexity of the self-attention model can be seen here, as the way practices are construed appears in the intertwining of various symbols – values attributed to milk and breastfeeding, as well as personal experiences and those of other women, including the interface with the Hegemonic Medical Model – which inform the explanatory models that justify the predominance of mixed breastfeeding in feeding children.

Theme 2: My family influenced my decision: I was able to breastfeed

The second theme emerges from two cultural patterns: *"My family supported me and I was able to breastfeed; My family thought that the baby needed other liquids in addition to breast milk"*.

Of the descriptors, it is interpreted that to some respondents, the reproductive phenomena in which breastfeeding is included are a part of women's nature, that has shaped them to give birth and nurse. However, the act of breastfeeding is also connected to culture, as one of the respondents argues seeking to anchor their decisions and practices in the Hegemonic Medical Model knowledge and not only in popular/family knowledge. In this cognitive exercise, she articulates two cultural models of health care, producing an explanatory model that guides her self-attention practices related to feeding a child.

It was easy for her to breastfeed, because she was born at home, so to speak. I had the baby when I was getting in the car and ended up going to the hospital because there were no midwives here. When we got there, they took care of her and she began breastfeeding, the same way it was with the others. All she ate was breast milk until she was five months old. I didn't even offer water because doctors recommend breastfeeding exclusively, unless you have no milk. But thank God, my children were all breastfed (F5 – mother / grandmother 05 – Larissa 3 years and 2 months).

It should be noted that even in families where the children accepted breast milk well, and were even exclusively breastfed for some time, the tendency to offer MBF, with the supply of water, juices, teas and other milks, also predominated.

Until up to six months he was on breast milk, sometimes we would try giving him XXX, but he wouldn't accept it, he would spit it out when he noticed it wasn't breast milk (F7 – mother 08 – Miguel 2 years and 7 months).

He was breastfed, yes [...]. I would give him some water, juice or something like that, but he wouldn't take it ... he wanted breast milk more than those things. So, after he was six months old we started to give him other things to eat (F2 – mother 2 – Nicolas 1 year and 8 months).

All respondents said they offered teas to calm the child, relieve cramps, discomfort generated by intestinal gas, and especially to treat colds and flus during the winter. For some, this is a sporadic practice that occurs when the child presents discomfort or illness.

Davi was breastfed when he was born. From time to time, I gave him some tea in secret ... (Giggles), it wasn't really a rule, but I offered it to him ... (F1- mother 1 – Davi 2 years and 4 months).

Sometimes, when they have a flu, we make some tea, but not always (F5 – mother 05 – Larissa 3 years and 2 months and grandmother 03 – Arthur 11 months).

Mothers who, when faced with difficulties, received support from their families and/or social networks and the Hegemonic Medical Model experts invested in breastfeeding with a successful outcome. In one of the families, the husband was instrumental in addressing the challenges posed by the initiation of breastfeeding, encouraging his wife to believe in her potential as a nursing mother.

I was giving him XXX and then my sister took Lucas to her breast because she had a bigger nipple than mine, and he sucked, even though she had no milk. From then on,

I would let him get really hungry and then I would offer him my breast and then he would suckle. So, I tried and tried, until I managed to breastfeed. Now he won't let go! When he was about four months old I started giving him porridge (F4 – mother 04 – Luke 2 years and 10 months).

When he was about 10 days old, he was crying a lot and then Daniel (Father) told me to try and breastfeed him again. He told me I could do it. And that's what I did. I took him to my breast and he suckled "(F3 – mother 3 – Cauã 1 year and 1 month).

This theme signals the necessary interaction of health professionals, among them nurses, with the family and social network that is closest to the mother, as the meanings governing family and social values are guiding the direction given to child nutrition.

DISCUSSION

Understanding culture as a network of symbols and meanings that guide the decisions of individuals and their social groups[7], and in this case, of families in rural areas in relation to infant feeding, it is interpreted that the choice for MBF, from before the sixth month of life and exceeding two years of age is, in the scenario under study, a self-attention practice. It refers, therefore, to practices managed by mothers and their family units in promoting a healthy child, among which some are proposed by Hegemonic Medical Model experts[8].

In the field of intentionality of self-attention practices adopted by families when feeding children, they operate both in the broad and restricted sense. In the first case, reference is made to meanings and practices for ensuring the bio-social reproduction at the level of micro-groups, especially domestic, operated from the objectives and rules established in the culture itself. In the restricted sense, they are specifically aimed ay coping with diseases/ailments[8].

The broad sense of MBF is represented by financial issues for its practicality and due to the affection developed through breastfeeding, which guides families towards this practice. Breastfeeding is a relevant option for this group's bio-social reproduction, since most of the families studied are from less privileged socioeconomic segments, who usually don't attend establishments that sell breast milk substitutes, since most of the food consumed by households is produced on the farm. Thus, breast milk is an alternative for these families because it is considered of good quality, always available and free of charge. It also dismisses spending with feeding bottles, bottle nipples and cooking gas, and other expenses arising from diseases that are more common in non-breastfed children[17].

On the other hand, the families concerned with the child's growth and development and, consequently, with the health/illness/care-prevention process, decide that MBF should be extended for a period that meets WHO recommendations[1]. In this logic, MBF takes the strict sense of self-attention practice, because when providing value to breast milk and the act of breastfeeding, the families decide for breastfeeding to prevent disease and promote health. It is emphasized that prevention is a structural part of self-attention, since it is up to society and individuals to produce concepts and use activities that protect aspects they consider threatening to the group.

Thus, in the broad sense and on its attention-prevention character herein, the self-attention practices here seized, have the meaning of "I'm doing the best for ...", like the Australian study conducted in rural areas[18], which seems to be anchored in Geertzian's culture design understood as *"models of and models for"* [7].

The data also indicate that this practice is autonomous because, despite interpreting that breast milk is good for the child's health, it is understood as not being enough on its own, from which a need to supplement arises. Thus, in terms of social conditions, the uniqueness of each mother and their families and symbolic representations of BF, to the child and the food produced in rural areas, the way children are fed becomes relatively autonomous[8]. Families opt for the inclusion of other liquids to feed the children, abandoning milk formulas by choice and opting for animal milk produced on their own farm or that of neighbors. It is noticed that MBF, before and after the child's sixth month of age, is a standard in that culture.

Moreover, the understanding of the explanatory models that support children's feeding decisions is important in promoting dialog between different cultures – in this case, the family and the Hegemonic Medical Model – since the way these models are built is not restricted to knowledge obtained in experiences shared with experts. The apprehension of meanings and meaning that produce explanatory models assists in the interpretation of how the self-attention practices are articulated, where it should be noted that they are the result of a transactional dynamic in which there is interaction of knowledge and practices of different health care subjects and spaces, operating as their referents[8].

It is clear, then, that the childrens' nutrition is not "pure" self-attention because, in addition to its broad and strict sense, it is aligned with more than one health care segment, since respondents' transit between the Hegemonic Medical Model and the knowledge of their own family and

community. The Self-attention Model will be produced within this transition – the articulator core of different forms of health care that these women and their families use in coping with situations that affect or may affect their health and that of their children, in a real or imaginary way, without necessarily suffering the direct and intentional interference of the Hegemonic Medical model experts, even if they are, sometimes, a reference[8,11].

Understanding this empowerment, of MBF's strict and broad meaning, and of explanatory models that guide the decisions of mothers and their families in relation to food offered to children is fundamental to overcoming old health care models, such as the Hegemonic Medical Model. Professionals in the health field, including nurses, subsidized by this understanding, may develop actions based on models that anchor the needs of each woman and family, their history and their momentary desires, respecting and sharing knowledge in an attitude of responsibility and true intercultural dialog[19-20].

The importance of mastery over and use of theoretical and conceptual contributions is thereby noticed in the cultural perspective as well, highlighting the concept of care accommodation/ negotiation [15] and the notion of intercultural dialog[20]. This concept refers to actions and decisions to assist, support, facilitate the people of a culture to adapt or deal with professional health care providers[15]. Intercultural dialog allows the establishment of meaningful and respectful relationships with different cultures other than those of the professional, who comes to understand the behavior and rationalization of others based on their personal and cultural perspectives. Understanding the social, political, economic and symbolic elements involving the health/illness/care-prevention are necessary in this interaction, and in this case, understanding the feeding process of children, as well as knowledge on issues involving power and mastery involved in human interactions, including intercultural communication[20]. From this perspective, the clear understanding of the roles of mothers and families in rural health in the care of their children is fundamental to effective and culturally congruent actions.

In the logic of intercultural dialog and care accommodation, it seems that, in establishing a relationship based on respect, leadership and autonomy, the professional can become a family ally, promoting health within the family core. To achieve this, it is emphasized that, in seeking a pragmatic solution to their ailments, it is the activities undertaken by the subjects and social groups that generate most of the connections between the various forms of attention, often surpassing the supposed or real difference or incompatibility that exists between them[8].

FINAL CONSIDERATIONS

The way children are fed in the rural areas studied is a form of health promotion and a disease combating process, like what occurs in other rural and urban settings. The similarity with the urban environment is identified, among other reasons, by the imprecision of boundaries, identified as respondents of this study are inserted in professional activities and services in this space.

When feeding a child, knowledge of different models of care are united – Hegemonic Medical Model and family/ popular models, articulated by the Self-attention Model. By uniting such models, the benefits of breastfeeding are recognized, and by choosing this practice, the family is shown as an important source of encouragement and support, helping to minimize the difficulties faced by the mother, which reflects positively on the health of the child.

Thinking of this study's contributions to the the field of children's health care, it is understood that the results provide information on the relevance of space in the academic training regarding content relating to cultural elements of care, in symmetry with others. This training will, in theory, allow the professional to integrate knowledge on culture that guides the health care of children and come closer to the cultural context of families, contributing to promote the healthy growth and development of children reflected in other phases of life, as food influences the quality and health conditions to old age, due not only to nutritional factors, but also symbolic factors.

The time spent in the field by the researcher can represent one of the limitations of this study, but the results are representative of the group and the context studied. However, it is noted that this study adds production of knowledge in a cultural perspective, and its interfaces in the health care of the child, indicating a fruitful field of research for nursing. Despite the contributions in the cultural perspective, it indicates the development of research in the rural setting in other approaches, due to the multidimensionality of the studied subject.

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