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Original Article

A EXPERIÊNCIA DA MULHER HOSPITALIZADA COM O RECÉM-NASCIDO NA UNIDADE DE TERAPIA INTENSIVA NEONATAL

THE EXPERIENCE OF THE HOSPITALIZED WOMAN WITH THE NEWBORN IN NEONATAL INTENSIVE THERAPY UNIT

LA EXPERIENCIA DE LA MUJER HOSPITALIZADA CON RECIÉN NACIDO EN NEONATAL UNIDAD DE CUIDADOS INTENSIVOS

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RESUMO

Objetivo: Conhecer a experiência das puérperas de risco, hospitalizadas com o filho recém-nascido internado na unidade de terapia intensiva neonatal. **Método:** Trata-se de uma pesquisa com abordagem qualitativa, de caráter exploratório. Participaram do estudo nove puérperas de risco, hospitalizadas. A coleta de informações ocorreu por meio de entrevista semi-estruturada e observação participante, analisadas conforme referencial da Análise de Conteúdo. **Resultados:** Emergiram 3 categorias temáticas: as relações estabelecidas durante a hospitalização; a rede de apoio tecida pela puérpera de risco; os desafios enfrentados pela puérpera de risco. **Conclusão:** Durante o processo de internação da puérpera de risco e do seu recém-nascido, essa enfrenta desafios que abrangem a lida com as mudanças de percurso do parto, do nascimento e da construção da sua maternidade, impostas pela sua condição clínica e do seu recém-nascido. O estudo aponta a necessidade de construção e fortalecimento de ações de cuidado voltadas ao bem-estar da puérpera de risco, hospitalizada e com o filho recém-nascido internado na unidade de terapia intensiva neonatal.

Descritores: Saúde materna; Recém-nascido; Unidades de terapia intensiva neonatal; Relações mãe-filho; Poder familiar.

ABSTRACT

Objective: To know the experience of puerperal risk patients hospitalized with the newborn child hospitalized in the neonatal intensive care unit. **Method:** This is a research with a qualitative, exploratory approach. Study participants were nine risk mothers hospitalized. Data collection occurred through semi-structured interviews and participant observation, analyzed according to the Content Analysis framework. **Results:** Three thematic categories emerged: relationships established during hospitalization; the support network woven by the puerperal woman at risk; the challenges faced by the puerperal woman at risk. **Conclusion:** During the hospitalization process of the puerperal women and her newborn, she faces challenges that deal with the changes in the course of delivery, her maternity birth and construction, imposed by her clinical condition and her newborn. The study points out the need build and strengthen care actions of the well-being of hospitalized risk puerperal woman and with her newborn child hospitalized in the neonatal intensive care unit.

Keywords: Maternal health; Infant newborn; Neonatal intensive care units; Mother-child relationships; Parenting responsability.

RESUMEN

Objetivo: Conocer la experiencia de las puérperas, en riesgo, hospitalizadas con el niño recién nacido hospitalizado en la unidad de cuidados intensivos neonatales. **Métodos**: Se trata de una investigación con enfoque cualitativo, desde la perspectiva de un estudio exploratorio. Los participantes del estudio fueron nueve puérperas de riesgo, hospitalizadas. La recolección de datos ocurrió por medio de entrevistas semiestructuradas y observación participante, analizadas de acuerdo a referencia del Análisis de Contenido. **Resultados:** Surgieron tres categorías temáticas: las relaciones establecidas durante la hospitalización; la red de apoyo tejida por el riesgo de las mujeres después del parto; los desafíos que enfrentan las puérperas en riesgo. **Conclusión:** Durante el proceso de internación de la puérpera de riesgo y de su niño recién nacido, ella enfrenta desafíos que abarcan el tratamiento con los cambios de recorrido del parto, del nacimiento y de la construcción de su maternidad, impuestas por su condición clínica y de su recién nacido. El estudio señala la necesidad de la construcción y el fortalecimiento de las acciones de cuidado del bienestar de la puérpera en riesgo después del parto, hospitalizada y con su niño recién nacido hospitalizado en la unidad de cuidados intensivos neonatales.

Descriptores: Salud materna; Recién nacido; Unidades de cuidado intensivo neonatal; Relaciones madre-hijo; Responsabilidad parental.

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INTRODUCTION

Although gestation is a physiological phenomenon and its evolution occurs in the majority of cases without intercurrences, there is a small number of pregnant women who, by particular characteristics, have presented a higher probability of unfavorable evolution, both for the fetus and for the mother, constituting the group called high-risk pregnant women[1].

In addition to the pathophysiological aspects, the literature points out the need to consider the psycho-emotional aspects when it comes to a high risk pregnancy, since the insecurities, doubts and fears can be enhanced because it is an event that puts at risk the life of the mother and the newborn[2-3].

At the end of a pregnancy considered to be of high risk, the puerperium - understood as the period of the pregnancy-puerperal cycle, in which the local and systemic changes caused by pregnancy and childbirth in the woman's organism, return to the pre-gravid state[4] - is not always free of risks. Uncertainties about maternal well-being may persist after childbirth and sometimes associated with uncertainties about the child's life. Maternal health status, such as premature rupture of membranes and hypertensive diseases, has a strong association with newborns who need care in the Neonatal Intensive Care Unit (NICU)[5].

Feelings such as fear of losing the child, mourning for the loss of normal pregnancy, preoccupations with the family, financial issues and work associated with the need for support in their activities of daily living are part of the daily life of this woman[6]. It should be noted that in this study, the term "postpartum risk" is related to the woman who is in a risk condition related to high risk pregnancy and demands postpartum care different from usual, requiring hospitalization in a specialized care unit.

When high-risk pregnancy causes the birth of a premature child who demands hospitalization, the woman experiences a spectrum of emotions ranging from boredom to anger. Feelings such as frustration, sadness, hope, irritation, impatience, guilt, fear, insecurity and anxiety are reported by them[2,6]. Therefore, the hospitalization of the puerpera at risk associated with the hospitalization of their child in the NICU can contribute to an even more challenging experience for the mother and child dyad due to physical and emotional frailty and the distancing of her child.

In the midst of this adverse context, the process of construction of maternity is given away. In response to this situation, the period in which a woman physically recovers, acquires abilities to care for and read the signs of her child, strengthens the mother-child relationship, and has as a reference the way of caring for other, more experienced people, it can be potentially challenging[7].

Within this context the questions that guided this study were formed: What is the experience of the hospitalized puerperal woman at risk with the hospitalized newborn child in the NICU? What are the challenges experienced by the puerperal woman in caring for themselves and the newborn child at hospital?

The simultaneous hospitalization of postpartum mother and postpartum child delineate a context of care with specific health needs. It is necessary to consider both the condition of the puerperal woman and her child, who demand differentiated care. Studies have explored the hospitalization of one of the components of the dyad, being incipient to address the concurrent hospitalization of mothers and their children soon after birth [6,8-10]. Therefore, it is necessary to explore the situations in which mother and child demand differentiated care after childbirth and birth. It is believed that the findings may indicate the challenges they face, contributing to the qualification of professional practice and organization of health services.

The study aims to know the experience of the hospitalized puerperal patients at risk with the newborn child admitted to the Neonatal Intensive Care Unit.

METHOD

This is a research with a qualitative, exploratory approach, carried out in the High Risk Pregnancy Unit (UGAR) of a philanthropic institution governed by private law, specialized in maternal and child care, located in Belo Horizonte, Minas Gerais. This unit is intended for the care of high-risk pregnant women and puerperal women who present some type of aggravation related to pregnancy and delivery and require special care. Together with the work of the medical and nursing team, the multi-

professional team also performs care according to the needs of the patients.

The choice of the theoretical referential of the dialectic is due to the fact that it allows apprehending a reality marked by contradictions and that is constantly in transition [11]. Therefore, when taking as an object of study the experience of the hospitalized puerperal patients at risk with the hospitalized newborn child at the NICU, we sought to understand the contradictions of the reality they experienced during the hospitalization. It was assumed that the puerperal women are human beings that exist in a certain time and space, establish relations and are inserted in a social reality that is in continuous transformation.

An active search was carried out by the participants in the tickets on duty at the unit and reading the medical records. Nine (09) puerperal women admitted to the UGAR, with a history and diagnosis that characterized pregnancy as being at high risk, their newborns hospitalized at the NICU of the same institution, and who presented clinical stability and conditions to perform the interview.

During the data production period, 22 postpartum women were admitted to the study unit; however, 8 were discharged from the unit to the ward on the same hospital day, and it was not possible to approach and observe them; 2 were transferred to another hospital due to clinical complications; 1 presented alteration in vision after delivery, it was not possible to read the Term of Consent and, therefore, not accepting to sign it; 1 whose newborn died; and 1 was a minor and without a companion to legally answer for her.

As instruments, the semi-structured interview and participant observation were adopted after a pilot test. The guiding questions of the interview were: "How is the experience of being hospitalized at the same time that your baby is in the NICU?; What feelings have you experienced at this time?; Who can support you at this time?; How are you and your family dealing with the situation of you and your child have been hospitalized?; What has helped you in dealing with this moment? And what has hindered you?; Have you taken part in your child's care? How?". Information related to maternal social identification, family history, gestational history, and clinical conditions of the puerperium and newborn were also collected.

The observations occurred at different times, days and spaces of the institution, according to the care routine of puerperal patients and newborns. Data collection was performed from February to April 2013, and was completed by the data saturation criterion[12].

To guarantee the privacy of the women who have just given birth, the approach was carried out individually and in a reserved environment. The interviews were recorded and later transcribed and submitted to content analysis, using the thematic modality[12]. With the application of the technique, the floating reading was performed to apprehend and to organize, in an unstructured way, important aspects for the next phases of the analysis; the selection of the units of analysis, identifying registry units that glimpse the purpose of the research; and categorization, defining categories that cover varied themes, which were grouped by similarity allowing the identification of three empirical categories[12]: the relationships established during hospitalization; the support network performed by the puerperal patient at risk; the challenges faced by the puerperal woman at risk. Subsequently, the inferences were made, the interpretation of the results found and the discussion, in light of the literature, pertinent to the theme[12].

The study was carried out in accordance with the guidelines regulating research, involving human beings, Resolution 466⁄2012 of the Ministry of Health, and it was submitted and approved by the Research Ethics Committee of the Hospital, study scenario (Opinion No. 179,788). The participants were guided with information about the study and, as far as their participation was concerned, the guarantee of preserving the anonymity and confidentiality of the information and that there would be no commitment to the care given to the newborn or her. All the puerperal patients who were approached accepted to participate in the study and signed the Term of Free and Informed Consent. For the preservation of anonymity, the following coding was adopted: participants (M), pediatrician (PD), nurse obstetrician (EO) and nursing technician of Neonatology (TEN). To identify the instrument used for data collection, the OP code was used for participant observation and E for interview, followed by the order of appearance of the excerpt in the interview or observed scene and, in the cases of observation, the time of its accomplishment (E.g., M5-OP11-22: 35h).

RESULTS AND DISCUSSION

The participants were nine puerperal women between the ages of 18 and 33, among them seven (seven) were married or had a stable union and who came from the interior of Minas Gerais. In six (6) cases, the newborn hospitalized at the time was the first child of the woman. Regarding previous pregnancies, 3 (three) of the participants had a history of high-risk pregnancy, from them 2 (two) had other newborns hospitalized at the NICU. Only one participant did not have the preterm newborn. The gestational age of the newborns ranged from 29 weeks and 2 days to 34 weeks and 5 days. Seven women progressed to cesarean section.

Regarding the length of hospital stay until UGAR discharge, the stay varied from 1 to 16 days. Among the reasons for hospitalization were increased bleeding, severe preeclampsia, Hellp syndrome and placental abruption.

The relationships established during hospitalization

The puerperal patients of risk demands specialized care and support to carry out the care with the child, needing more support and contact with the health team.

In view of the context of gravity, the breast-feeding woman establishes a relationship of safety and trust with the institution, realizing that there are the necessary resources to assist her and to meet the health needs of the newborn child, such as trained professionals and technological apparatus:

"You know that I'm in a safe place, that I'm not anywhere! If, God forbid, I gave birth there in my city, something could happen to me or the baby. I'm feeling pretty good to know that I'm in a safe place. " (M1-E10)

This relationship of trust in the team is important to be established, since the absence of appropriate support or accompaniment can trigger insecurity, fantasies and doubts about the service offered[13].

The fact that the newborn and his mother require specialized care is a limit to the contact between mother and child in the initial moments after birth. Added to this, the physical pain, the difficulty of getting around, the weakness and the effects of the use of the medication are aspects that sometimes hinder, sometimes prevent the women from staying with the child in the NICU.

"What has made it difficult is that I cannot get up and go to see him because he's in the ICU and I'm hospitalized too, so it's really difficult. Also, it's not any time that I can get up, walk out and go there." (M7-E10)

The clinical and hospitalization conditions of the woman modify the experience of motherhood in this initial phase. When demanding specialized care to restore her condition, the puerperal woman becomes more of an object of care than someone who can care for her child.

The period immediately after the admission of the newborn to the NICU may be one of the most stressful for the mothers[14], causing apprehension and impairing the establishment of the bond[15]. When the risk situation involves both the puerperal and the newborn, with consequent hospitalization in different care units, these negative feelings can be intensified.

Although the woman is in an intensive care unit, rather than merely recovering her clinical condition, there is also a need to establish supportive care.

Therefore, it is recommended that a professional team visit the mother still in her inpatient unit, transmitting news about the newborn. This behavior makes her feel more confident with the team, and some of her concerns are minimized or healed[9,13]. One strategy to favor contact between mother and child, when it is not possible for mothers to go to the NICU, is to make use of photographs of the newborn[9].

In addition to anxiety, feelings such as fear, stress, impotence and guilt are often related to women at risk in the puerperal pregnancy cycle because of the vulnerability to maternal and infant health [16-17]

The present study obtained, as findings, the feelings of impotence of the puerperal women before their condition of anxiety for news and the expectation of meeting the newborn.

During the hospitalization of the puerperal patient at risk, as soon as they have clinical conditions, they are encouraged to go to the NICU. This access to the NICU enables the puerperium to obtain information about the newborn child, as well as creates possibilities to become involved in care practices. In some situations, the mother uses the touch, the look and the voice as a way of being close and interacting with the child.

"[...] PD1 explains about the baby's respiratory condition, [...] also guides the manual extraction of milk, where the collection room is

located and asks the mother to request more guidance from UGAR. In the end, confirms again with M2 if she understood the information, who says yes." (M2-OP7-10: 00h)

"[...] The mother returns to her son's bed, bends forward to approach the newborn's face and offers her finger to hold the baby. M2 starts talking to her son, who calms down and opens his eyes." (M2-OP14- 9: 20h)

Stimulating the free and early access of the mother to the NICU favors the establishment of the mother-child relationship[13]. It is worth mentioning that the institution where the study was conducted allows parents to have free access to the NICU. This aspect allows moments of contact between mother and child as soon as the puerperal woman is able to go to the unit, which can contribute to the strengthening of the bond and to opportune the participation of the mother in the care of her child.

At the first visit in the NICU, after the parents know the environment and realize that the newborn is receiving all the necessary treatment, they feel safe to trust the child's care to the health team[13]. Thus, it is necessary for the health professional to guide the mother and her family in a clear and objective way about the devices connected to the newborn, the care he needs, the prognosis, and the routine of the unit.

The puerperal women value the opportunities to accompany the care of the newborn performed by the team. It is observed that, in the relationship established between the health professional and the mothers, the clarification of doubts about the health conditions of the newborn by the professional favors the construction of possibilities for the puerperal patients to become involved and to participate in the care with the child in the NICU.

"[...] M5 stays by the crib carefully looking at the procedures and asks the professional about the son's milk. The technician says that the diet is suspended, but she reinforces the importance of M5 to extract the milk to stimulate its production and explains to the mother where the collection room is. TEN7 asks M5 to change sides and says she will put the baby on his mother's lap to clean the crib". (M5-OP20 - 9: 00h)

Although the puerperal patient has access to the information about the child admitted in the NICU, situations are observed where the dialogue established between the puerperal woman and the health professional can be compromised due to the use of technical terms, rendering the information incomprehensible and inaccessible to the first one.

"[...] TEN5 connects the Bilispot® and directs the baby's focus of light, explaining to M5 that the baby is in the light because his skin is very red and that he will certainly have jaundice. M5 questions what jaundice is and TEN5 answers it is the rise in blood bilirubin "(M5-OP11-22: 35h)

It is also verified that the power relations established between puerperal women and health professionals are present in the daily life of the NICU, as in the situations in which the professional decides when to meet the mother's information needs:

"Stopped facing PD3, M5 says, 'Can you see if my baby is okay?' PD3 says that she cannot give news at the moment because it is not in the news schedule". (M5-OP13 - 22: 37h)

The suffering experienced by puerperal women can be exacerbated when they do not obtain information about the newborn hospitalized in the NICU. Poorly informed, they show insecurity and anxiety. Even health professionals who are aware of the importance of providing information, their supply is still insufficient, little clarifying and occurs according to the dynamics of the unit and routine of the professional and not based on the mothers' needs [18]. Added to these aspects, the abuse of technical terms and the devaluation of the maternal emotional aspects by the health professionals create barriers, favoring the distancing and conflicts in the relations between mothers and the team[13].

In the assistance of the information needs of the newborns' mothers who were admitted in the NICU, it is important to respect and to consider the uniqueness of the needs not only of the hospitalized newborn, but also the woman's in her condition of hospitalization and as the newborn's mother. Therefore, it is necessary for the team to exercise the listening ability to enhance their ability to respond to these needs [6,8-10]. In this sense, in the meetings between parents and professionals, it is important to establish a dialogic relationship, making it possible for the needs of professionals and parents to be met in a more concrete way[8].

To the extent that the relationship established between the family and health professionals allows an expanded view, which considers the needs of building and strengthening bond, dialogue and acceptance, the possibility of

the production of an integrality-oriented care is open[8].

The support network performed by the puerperal patient at risk

The study revealed how the support network of these women is activated and redesigned. With the hospitalization of the puerperal woman and the newborn child, social bonds are weakened, others are strengthened, and new support relationships are established in daily life.

Since the hospitalization in high-risk pregnancies, there is a predominant need for social support for these women, due to the separation of family members and feelings of social withdrawal[19]. This support remains essential for the postpartum risk woman who remains hospitalized.

The reports show that the network of support of these patients is made up of family members, neighbors and friends and that, even geographically distant, this is a group that helps them. It is worth mentioning that the presence of the maternal figure seems to be more prominent, since it is the mothers of these puerperal mothers who accompany them in the hospitalization process, and when this is not possible, this absence is felt by these women:

"I'm counting on the support of everyone in my family. They are not all here with me, but everyone is supporting me, they call me during all day." (M5-E1)

"Now that I really need her [mother], to help me to give a bath, something like that, she can't come!" (M6-E6)

During hospitalization, health professionals also begin to form the network to support postpartum women at risk. It is evidenced that the patient recognizes the support offered by the professionals, especially in the situations in which the people who could assist cannot be present.

"What helped me was the people here [health professionals] who talked to me, because I was very nervous. [...] Because if it were not be possible, I would be desperate, I would not know what to do! Well, I was been assisted by others, because my family could not help me!"(M6-E7)

Social networks comprise not only the nuclear family or the extended family, but can be defined by the availability of support and reinforcement by significant systems or individuals, in situations of crisis, favoring coping strategies through caring, encouragement or assistance[20-21].

In the first moment, the puerperal women seeks support in the people with whom she maintains greater coexistence, such as the companion and family[10,22]. When the woman does not find in this group someone to support and accompany her, the hospitalization process becomes more difficult. Thus, it is important that health professionals are sensitive to maternal and family needs during care and are recognized as a source of support through kindness[3,9-10].

The lack of support from the team for involving parents with infants in the NICU carries a high level of stress, anxiety, harmful interaction and promotion of integral care[23].

It should be noted that the majority of the study participants came from cities in the interior of the state that did not have the resources to meet their health needs and their newborn. In this sense, it is necessary to consider the need for health institutions to ensure the puerperal women and newborns the right of accompany, contributing to minimize the distance between mother, newborn and family, due to the period of hospitalization.

The stay of the companion during the hospitalization allows the latter to offer emotional support to the mothers, as well as to assist in the activities of self-care and in the care of the hospitalized child. Added to this, in some situations, the companion talks about to the needs of the puerperal woman and facilitates access to the information about the child hospitalized in the NICU.

"M2 complains pain in the belly and says she cannot go up to the collection room to milk. The companion goes to the nursing station, goes to the EO1 and explains that at the NICU, they asked M2 to withdraw the milk to offer the baby, but she will not be able to go up to the collection room because of the pain and weakness." (M2-OP10- 10: 40h)

"M1 says that the son is well and because she is not able to walk at 11:00 a.m., her husband goes to the NICU to receive the news. She also reports that the husband photographed the son to show it". (M-OP-10: 55h)

Both the faith and the child interned in the NICU appear as constituent elements of this support network, enabling the puerperal women to feel empowered to overcome the situation experienced.

"It's just God and she [newborn daughter], because I have to be strong to take care of her. So,

we just have the strength to overcome this phase." (M8-E4)

Women living in a similar situation provide a source of support for the puerperal patients, especially to adapt to the care routines related to the newborn hospitalized in the NICU.

"In the collection room, M4 asks another woman to take the milk by her side, how to attach the identification tag to the syringe and asks her to remind her about the name of the place where she should take the milk. The puerperal woman says she is going to the milk room and that if M4 wants she can go with her [...]". (M4-OP14- 19: 00h)

This recognition of the feelings in other puerperal women in a similar situation causes that women do not feel alone and realize that they can support during this trajectory [10]. Social networks have characteristics that involve variables of its structure, its functionality and the attributes of its link[20]. Based on this characterization, among the various functionalities of the network, it can be considered that the postpartum woman at risk and the child hospitalized in the NICU require, in particular, a network whose function is emotional support.

Therefore, the creation of support groups for mothers, conducted through the educational, psycho-emotional and social support, can be configured as strategies to expand and strengthen this support network. The strategy of support groups is a practice implanted in the institution, scenario of this study. Different types of support groups are offered to mothers of newborns admitted to the NICU by the multi-professional team[8]. However, we take into account the fact that puerperal woman at risk, hospitalized at UGAR and the child at the NICU, are not included in this type of care yet.

The challenges faced by the puerperal woman at risk

The hospitalization of the postpartum woman at risk and the newborn child generates changes that can be configured as challenges to be faced by the woman. One is about the change in the course of her gestation when she finds herself confronted with the need to deal with frustration in the face of unmet expectations and to elaborate a new reality, sometimes distant from the one previously imagined:

"It's too frustrating! I hoped to win, to recover and to leave. But I'm trying to stay calm now." (M2-E1)

This challenge may be related to the fact that, when the woman is a high-risk pregnant woman, her delivery process tends to be focused primarily on medical procedures aimed at her and the newborn, to the detriment of her feelings, values and beliefs are taken into consideration from prenatal to birth [3,10]. In addition to the way of birth and delivery take place, the child is still premature or requires intensive care.

The hospitalization of the mother and the newborn in separate units is a situation that generates suffering for the woman, establishing limits so that she can care for and interact with her child, as expressed in the following report:

"The distance makes it all difficult because if she was here, I could be looking at her all the time. [...] I think worry makes us worse, because, with anxiety, we do not rest. Tonight, I did not sleep at all, I was worried! "(M8-E5)

"[...] when you get a normal child, you get it on your lap. And, yesterday, I could not do it because it's premature and you cannot take it [...] it's different, it's weird! I cannot explain!" (M6-E5)

This difficulty encountered by the puerperal woman to be closer and have opportunities to interact with their child is intensified by the limitations presented by the newborn hospitalized in the NICU, such as clinical instability and still immature abilities to engage in an interaction, recognition and interpretation of their behavior by the mother[15].

Knowing that your child will be born prematurely, the high risk pregnant woman experiences the feeling of apprehension that, in the puerperium of risk, gives rise to the feelings of anxiety, uncertainty and fear before the premature birth and its health condition. The knowledge of belonging to a risk group makes the woman more able to have tiredness or psychological stress[10].

Thus, the puerperal women need to be comforted and enlightened in the face of unexpected and bad events, and to receive support in facing the challenges posed by the risky puerperium.

Another challenge refers to the health conditions of the puerperal woman, who compromise her participation in the care of the child, such as feeding, bathing, changing diapers and holding in her lap. In this situation, the mother recognizes their limitations and seeks to

take care of themselves in order to have conditions to care for the child.

"I have gone there, I have taken the milk for him, every time I take care of getting up, I go there to see him, pray for him ... I am taking care of him, drinking plenty of water, eating right, to stay strong and able to take care of it! "(M2-E7)

The inability to perform the typical tasks of being a mother is a potential stress factor for mothers, and may negatively influence their ability to learn about the care required by the newborn and prepare to take care[14].

The construction of maternal identity is influenced by maternal factors such as the perception of the birth experience, early separation of the child, stress, anxiety, state of health, perception regarding the child and conflict of roles; by factors pertinent to the child, which include the ability to give signs, health and appearance; and environmental factors, including family context and social support[7].

In situations in which the mother presents conditions and expresses their desire to participate in the care of the child, this participation is not always favored by the health professional.

"[...] TEN7 takes the baby again and puts him in the crib, he is crying. TEN7 begins to calm the baby, meanwhile, M5 takes twice in the son's hand, but with the handling of the technique, the hands have eventually moved away. M5 asks the technician if he cleans it every day at the same time and explains, smiling, that he wants to follow the care every day [...] "(M5-OP21-9: 00)

Despite the existence of a discourse in defense of the presence and participation of the mother/family in the NICU, this presence can be seen as a problem for health professionals, as it demands that the professionals dedicate themselves to assist in the social, affective reorganization and psychological[13].

The possibility of the mother in NICU care has been defended based on the understanding that it will bring benefits to the health of the newborn and contribute to the safety of the parents in relation to the care of the child [18]. It is important to emphasize the importance of stimulating maternal contact with the newborn; the realization of the kangaroo position and the manual extraction of milk [19]. It is also evidenced the essential role of professionals, especially nursing professionals, to increase understanding and the feeling of maternal participation in the care of their child[6,22,24].

Therefore, it is imperative to guide the hospitalized puerperal women, qualifying their knowledge about the newborn's behavior[25] and working with them to build possibilities for the care of the newborn child during the ICU stay, since many women bring with them expectations about what caring in a healthy and full-term birth situation, and it is also necessary to construct alternative contributions in the NICU's hospitalization situation. This process of construction and discovery of new possibilities is that it will favor their participation in the care of the child and soften the feeling of loss of the maternal role.

Considering the interferences that the health condition of the newborn has in the form of coping of this situation by the mother and the experience of the maternity, it is necessary that, in the process of care to the puerperal woman at risk, the processes of illness are considered mother and son.

Even when there are no clinical conditions, the mother wants to take care of her child. In such cases, it is recommended that guidelines be drawn up for a professional practice that creates conditions for women who are heavily dependent or need intensive care to facilitate their visit to their baby or vice versa[9].

FINAL THOUGHTS

The study revealed how the experience of the woman hospitalized with the newborn hospitalized is in the NICU and how this context transforms her maternity.

During the hospitalization process of the puerperal and her newborn, she faces challenges that deal with the changes in the course of delivery, birth and the construction of her maternity, imposed by her clinical condition and her newborn, born. Such challenges can be intensified or mitigated according to the physical and emotional factors of the woman and the organization of her support network, composed of the relationships she establishes with the newborn child, the next family, women in a similar situation, and the health professionals.

In particular, when health professionals contribute to the needs of the puerperal and the newborn's needs, they become part of the network of support for puerperal women, and strengthen it, especially when other sources of support available are fragile. However, this relationship is also challenging for coping with the process of both hospitalizations and the

participation of the woman in the care of the newborn child, as the health professional does not offer the opportunity for the mother to be participatory and active in the maternity, and does not establish an effective dialogue with the puerperal in particular on information related to the newborn.

In view of the understanding of the health needs of these puerperal women, their challenges and potential sources of support, and considering the proposals of the Ministry of Health to improve the quality of prenatal care, delivery and puerperium care, the construction and strengthening of care actions aimed at the well-being of the puerperal woman, her newborn and her family. In this perspective, it is recommended to create spaces of conversation so that the mothers can express their feelings; to foster early contact between the puerperal and the family with the newborn in the NICU; to create possibilities for these mothers to participate in the care of the child; to establish a communication process in which health professionals are sensitive to the information needs of the women who recently gave birth and family; investing in the permanent education of health professionals, making it possible to acquire knowledge in order to meet the care needs of the puerperal woman, her newborn and her family.

As a limitation of the study, the fact that it was carried out in a single scenario stands out. It should be pointed out that, for this study, the perspective of the women was sought and the data collection was performed during part of the hospitalization. It is suggested to carry out studies that consider the perspective of other individuals, such as family members and professionals of the health team. Longitudinal studies can investigate the different stages of hospitalization, as well as the repercussions of this long-term experience for puerperal and their newborns.

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