



CARE FOR NEWBORNS IN PUBLIC MATERNITY HOSPITALS ASSISTED BY THE *REDE MÃE PARANAENSE* PROGRAM: MATERNAL EXPERIENCE¹

Maicon de Moraes de Miranda*

Juliane Pagliari Araujo**

Sebastião Caldeira***

Rosângela Aparecida Pimenta Ferrari****

Adriana Valongo Zani*****

ABSTRACT

Objective: to understand the maternal experience regarding the assistance to the newborn in public maternity hospitals. **Method:** qualitative, phenomenological study, based on the theoretical-methodological framework of Alfred Schütz. Data were collected with a sample of 30 mothers of newborns, through semi-structured interviews, from February to July 2018. The interviews were conducted at the mothers' homes. **Result:** Mothers experienced moments of joy, but also of suffering in relation to the birth and care of their children in the first hours of life, and due to this experience, expectations regarding assistance for some were beyond expectations and for others caused frustration as can be observed in the two categories that emerged from their reports: The first concerning the lived experience, that is, the "reasons why" Experiencing the first hours of life of the child in the maternity services (Delivery Room: approaches and distance from contact; Joint accommodation: (re) learning the care of the baby; Support breastfeeding; Lack of communication, Guidelines for discharge and Gratitude for the assistance received), the second category brings the expectations, the "reasons for": What you expect from the assistance in the first hours after the birth of the child (Quality assistance and Accompaniment in childbirth: desires and challenges). **Final considerations:** the experience of birth was taken with moments of interaction and contact with the newborn, but also of little contact due to procedures and interferences. The mothers experienced moments of learning and also verbalized the absence of the professional, generating desires and expectations to improve the quality of care.

Keywords: Newborn. Maternity Hospitals. Maternal and Child Health. Neonatal Nursing. Nursing Care.

INTRODUCTION

The assistance to the newborn (NB) involves numerous factors and its realization can cause considerable impacts on the lives of those involved. In order to improve the coverage, humanization and quality of maternal and child monitoring, in 2011, the *Rede Cegonha* Program⁽¹⁾ was created at national level, and in the state of Paraná, in 2012, the *Rede Mãe Paranaense* Program was implemented aiming, through a care network, to ensure quality maternal and child care, in addition to ensuring the child the right to a safe birth, enabling healthy growth and development^(1,2).

Integrating these health and neonatal care policies are the Sustainable Development Goals

(SDGs), with an agenda until 2030, whose goal, through "SDG 3: Good Health and Well-Being", is to have no neonatal and infant mortality from preventable causes⁽³⁾.

During the neonatal period, the child is susceptible to numerous risks, making integral care essential. It is understood that the care and assistance provided to mothers and newborns can influence health conditions, from the neonatal period to adulthood, and can strengthen the mother-child bond that is essential for their affective, emotional and social development^(4,5).

Thinking about it, since the birth of the newborn, a care that ensures that this bond is developed is recommended, providing skin-to-skin contact and breastfeeding from the first hour of life and preventing both from being

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*Nurse. PhD student in Nursing by the Graduate Program of the State University of Londrina (UEL), Paraná, Brazil. Email: maicon_moraesuel@yahoo.com.br. <https://orcid.org/0000-0003-0121-429X>

**Nurse. PhD student in Nursing by the Graduate Program of the UEL, Paraná, Brazil. Email: juliane.pagliari@fpr.edu.br. <https://orcid.org/0000-0001-7821-6731>

***Nurse. PhD in Nursing. Professor of the Undergraduate and Graduate Nursing Course at the Universidade Estadual do Oeste do Paraná, Paraná, Brazil. Email: sebastiao.caldeira@unioeste.br. <https://orcid.org/0000-0003-2827-1833>

****Nurse. PhD in Sciences. Professor of the Undergraduate and Graduate Nursing Course at the UEL. Email: ropimentaferrari@uel.br. <https://orcid.org/0000-0003-0157-7461>

separated for unnecessary procedures during birth until both are referred to rooming-in, providing the creation and development of an experience that will accompany the mother throughout the period of the baby's development⁽⁶⁾.

The rooming-in (RI) is a hospital system that promotes the interaction between mother and child, allowing the healthy NB to remain with the mother 24 hours a day, aiming at the care and identification of risk situations, enables the promotion of breastfeeding, involvement of parents and a humanized assistance, as well as the reduction of infant mortality^(6,7). The permanence of the binomial in the RI is related to direct and integral care, with the objective of developing the bond between family members and the baby, highlighting the guidelines and health education, carried out and guided by the nursing team^(6,8).

Given the importance of this theme, there is a need to understand how these mothers are experiencing the assistance to the newborn from birth to their follow-up in the rooming-in, so this study starts from the following question: How did the mother experience the assistance offered to the child in maternity in the first hours of life? Therefore, the objective of this study was to understand the maternal experience regarding the assistance to the newborn in public maternity hospitals.

METHOD

This is a qualitative study based on the theoretical-methodological framework of Alfred Schütz's Social Phenomenology, from the experience lived by individuals, through the relationships developed in the world of life, where the individual's experience takes place and in the social world, where their social relations develop⁽⁹⁾.

Thus, the assumptions of phenomenology help understand maternal experience, namely: natural attitude; social world and world of life; social relationship face to face; subjectivity and intersubjectivity; knowledge stock; motivation – “reasons why” and “reasons for”; reciprocity of intentions and typification.

These behaviors, actions and different types of experience are driven by motivations,

structuring and categorizing themselves in the experience related to the present and the past, based on the antecedents, the collection of knowledge, experience in the biopsychosocial context of the person called “Reasons Why”. On the other hand, the experience that relates to the achievement of goals, expectations and objectives directed to the future is called “Reasons for”⁽⁹⁾. In this sense, Social Phenomenology allows understanding maternal life from her social relations⁽¹⁰⁾. Thus, this study sought to deepen the “reasons why” and “reasons for”.

This study is part of the multicenter research project entitled “*Rede Mãe Paranaense* from the user's perspective: the assistance to the woman in prenatal, childbirth, puerperium and to the child”, funded by the National Council for Scientific and Technological Development – CNPq Call 14/2013, n.474768/2013. This program, in 2022, underwent some changes and received a new denomination: Maternal and Child Care Line of Paraná⁽¹¹⁾.

The selection of mothers occurred through intentional selection, in order to ensure representation of all regions of the city. The sample consisted of 30 mothers, residents of a municipality in the northern region of Paraná, distributed as follows: residents in the southern region 08; north 08; east 05; center 04; and west 05.

The inclusion criteria were: live in the urban area, with delivery performed in one of the two public maternity hospitals under study, one of Normal Risk (NR) and Intermediate Risk (IR) and another of High Risk (HR), have performed prenatal care in Primary Health Care (PHC) and use the Basic Health Units (BHU) for monitoring the child's health.

Data collection occurred from February to July 2018, six months after delivery, since the purpose of the matrix project was to evaluate the entire process of pregnancy, birth and monitoring of the child in the first six months of life by the *Rede Mãe Paranaense* Program. Moreover, it was considered, in addition to the moment of birth, to remain alive in the maternal mind, in the first days after childbirth, numerous feelings, as well as physical discomforts that could interfere with her experience.

The place of collection was the mothers'

home, and the instrument used was the semi-structured interview. After acceptance by telephone contact, the interview was scheduled on the mother's availability date and started after reading and signing the Informed Consent Form. The interviews were conducted after the application of pilot test and training of interviewers.

The guiding questions to boost mothers' reports were: Tell me about your experience in experiencing labor and puerperium. Was the birth experience as you imagined/planned? Tell me how was the assistance you received after the birth of your child in maternity? At hospital discharge, after the birth of your child, did you receive any guidance on which health service to seek for the continuity of child care? What kind of care did you expect from the services and health professionals of your municipality/regional during pregnancy, childbirth, puerperium and care of your child? What do you expect from services, public policies, and programs focused on birth care and post-birth baby care for you and other women?

The average duration of the interviews was approximately 50 minutes, considering the initial interaction and the interview itself, all recorded on an Android mobile phone. At the end, the mother was asked to listen to the recording, granting her the right to change the information if she considered it necessary. The data were fully transcribed, and the audios, deleted afterwards.

The analysis and organization of the material followed the following steps: 1st- careful and attentive reading of each report in order to understand and grasp the general meaning of social action implicit in the speech; 2nd- full re-reading of each speech to identify the common aspects that manifest the contents of the "reasons why" and the "reasons for"; 3rd- common aspects based on content convergence to build the compositions of the categories, typifying and grouping them based on similarities and congenital reports; 4th- analysis of each category aiming to understand social actions; 5th- construction of the maternal experience from the set of "reasons why" and "reasons for" showing the understanding in the analysis of the categories; 6th- discussion of the maternal experience in the light of Alfred Schütz's Social

Phenomenology^(9,12).

In order to maintain the mothers' anonymity, they were identified with the letter "M" followed by the number corresponding to the order of execution of the interviews, followed by the acronyms according to their gestational risk stratification, being NR – Normal Risk, IR - Intermediate Risk and HR - High Risk.

This study met the ethical and legal issues with favorable opinion n. 2.053.304, CAAE: 67574517.1.1001.5231 by the Research Ethics Committee.

RESULT

Regarding the characterization of the participating mothers, the age ranged from 15-42 years. Regarding gestational risk stratification, 15 (50%) were classified as Normal Risk, 6 (20%) as Intermediate Risk and 9 (30%) as High Risk. As for schooling, 13 (43.3%) had completed high school, with family income ranging from 600 BRL to 4,500 BRL, 21 mothers (70%) had no paid occupation.

The NB Apgar ranged from 5 to 9 in the first minute of life and from 8 to 10 in the fifth minute of life. Regarding the route of birth, 14 (47%) were vaginal deliveries and 16 (53%) were cesarean. The gestational age ranged from 36 to 40 weeks.

In the analysis of the mothers' speech, two categories were identified. The first refers to the "reasons why", that is, the experience already lived: "Experiencing the first hours of life of the child in maternity services", subdivided into: "Delivery Room: approximations and distancing from contact", "Rooming-in: (re)learning the care of the baby", "Breastfeeding support", "Lack of communication", "Discharge guidelines" and "Gratitude for the assistance received"). The second category refers to expectations, the "reasons for": "What to expect from care in the first hours after the birth of the child", with two subcategories: "Quality care" and "Accompaniment in childbirth: desires and challenges".

Experiencing the first hours of life of the child in maternity services ("reasons why")

Delivery Room: approximations and distancing from contact

Among the “reasons why”, it was seized the experience of mothers during the care of their child after birth. It is known that, at birth, the contact of the NB with the mother in the first hour of life is essential, providing numerous benefits for the binomial as strengthening the bond, promoting breastfeeding and reducing infections.

Some women had this moment guaranteed and appropriate as recommended, this moment brought them positive feelings:

They put him in direct contact with me, he stayed for about 10, 20 minutes of contact with me, on my body. Then they came and put my nipple in his mouth, for him to suck, he began to suck slowly, then onwards he didn't stop sucking (M28IR).

He was born, was with cord and everything, first contact was with me. The nurse, I even remember her name, was so lovely, gave much attention, after he was born (M25NR).

For some mothers, skin-to-skin contact was interrupted in the first hour of their children's lives to perform procedures that were not necessary at that time.

[...] incredible as it may seem when he (professional) showed me, she wasn't even crying, so he put her on my breast, then he took her and me to the room to bathe her (M19NR).

I've just delivered, they put him in my lap, no need to cut anything. I just held him, then they cut the cord, then they took him out of my lap to clean him (M13NR).

She was born and they already brought very close to me and close to the father [...] put, so only took out for the pediatrician to evaluate, he came back with her, so she was about forty minutes, almost an hour on my breast, she already latched on correctly, needed no help (M16NR).

With some mothers, skin-to-skin contact did not occur immediately after birth, justified by professionals as the need to first perform routine procedures such as hygiene and aspirations and thus the first closer contact with the child occurred later:

He was born [...] I heard his cry. But they had already warned me that they would not show me soon after, because they would first make an aspiration, clean and that soon after would take him. But it wasn't because he wasn't well, it was a normal procedure. They just did this cleaning, and showed me. I've just had time to give him a kiss, then he was gone, they took him (M6HR).

I just saw him, really fast, they were winding him up, cutting the umbilical cord to bring him back. [...] only after I left the operating room I breastfed him (M23NR).

They showed him [...] Only showed [...] After 5-6 hours [...] he came to stay with me, I think it was to wait for anesthesia to pass. (M5HR).

However, it can be observed that some mothers did not have the opportunity to make skin-to-skin contact with their children immediately after birth due to maternal complications, or due to complications with their child, which brought memories and feelings that marked the moment, leading them to visualize differently from the others the birth of their children, but that justify not having contact immediately after birth.

She wasn't close to me [...] I was afraid of my baby not being well {crying} [...] I didn't like it because she wasn't close to me, went straight to the incubator [...] difficulty breathing [...] referred to ICU, I could only see her at night [...] it was not a good thing, I couldn't stay with her in my lap (crying), only after two days (M26IR).

During childbirth I ended up feeling sick [...] At this time they (professionals) only put my head aside, a cloth, then at that moment they had already taken her (baby), and by the time they took, she was very red, showed me her crying, my husband was there beside me, he couldn't stay around her, but he could see from where he was and I was all the time looking at her, and they were doing things, and my husband told me that it was okay with her. [...] Then they (pediatricians) brought the baby for me to see but very little, showed and took her (M1HR).

The absence of skin-to-skin contact and the need for separation of the child even if for a short period of time remain alive in the mothers' speech, and thus it becomes paramount that the professional identifies this moment, and, as soon as possible, favors this contact.

Rooming-in: (re)learning the care of the baby

The rooming-in is a space that should favor learning moments related to the care of the NB, enabling strengthening of the mother and child bond, as well as providing maternal and paternal empowerment in the care of the child. For some mothers, the period of rooming-in brought knowledge and can be observed reports regarding the support received in the accomplishments of care, but for others, moments of dissatisfaction and lack of support from professionals emerged.

The girls {professionals} helped me breastfeed, taught me how to latch on, taught me how to bathe, taught me how to take care of the navel, taught me how to breastfeed, I've learned a lot (M20NR).

Practically we had no help from anyone. To bathe, these things, I had no help from anyone, I did everything myself. They came in just to give the medicine to me, because I said I was colicky and alone (M25NR).

Breastfeeding support

During the period when mothers remain in the rooming-in, some care should be performed, such as support and breastfeeding support, because for many infants, the onset of breastfeeding can be challenging, thus, it is necessary that professionals working in maternity services assist at this time.

I had more difficulty breastfeeding, because my breast had no beak, so he didn't latch on. [...] All the time she came to help, to teach (...) (M7HR).

I had difficulty breastfeeding because it hurts a lot to breastfeed, the first days are very difficult, but as my son needed to stay in the light bath I stayed one more day and in the maternity hospital, they helped me breastfeed and gave me an oil to help improve, it was calm (M2HR).

I had a bit of trouble for her to suck, because I had no beak, but the speech therapist helped me a lot (M3HR).

Lack of Communication

The difficult communication due to

misunderstood information between the professional and family, as well as the absence of active listening by the professional were punctuated as expectations that generated frustration regarding the assistance received.

They {professionals} are not that good, many things they don't inform properly, don't pay attention and don't listen to what we have to say (M1NR).

I was very disappointed with some professionals, because I realized that some don't believe what we are talking about, actually don't even listen, when I was in labor, I asked them to call the doctor, because the pain that I was feeling changed and lost a green liquid, but he said it was nothing that everything was right, didn't even examined the liquid, and then I had to go to emergency cesarean because my baby had pooped in the belly and was serious, if it weren't the fast nurse, maybe I would not have my son here (tears). (M4HR)

Discharge guidelines

For most mothers, one of the most expected moments during the hospitalization period in the rooming-in is discharge, as they wish to return to their homes, each for individual reasons and needs. However, for the professional, this moment should be to rescue the guidelines that must have been carried out throughout the process of rooming-in in order to ensure continuity of care and follow-up for both mother and NB.

Guidance on baby care, breastfeeding and as my blood pressure had not yet lowered he directed me to go to the CH {clinic hospital}, I was instructed to go for follow-up (M10HR).

He guided where he needed to go back to get the neonatal heel prick, if everything was okay, I would be referred to the BHU [...] passed the dentistry staff referring for assistance at the BHU, the pediatrician also talking to schedule the childcare at the BHU (M16RH).

Gratitude for the assistance received

Some women reported the moment they were in the maternity hospital as positive, reporting a pleasant experience, feeling that they received good care, thanking the same, the

assistance and respect received.

I would like to say that they aren't professionals, they are true angels! I was very, very well assisted. I was afraid of the hospital that my son was born, everyone spoke things, but I recommend (M8HR).

I felt cared for, I thought it was very good, I think I really wanted to be able to find the girl who did my childbirth, because she was as emotional as I was, that was very good for me, because when I was there, at the moment giving birth, I looked at her and her face, her little eye was shining from me giving birth (laughs)[...] it's special to me, I looked at her and it was being special to her too [...] (M29NR).

What to expect from care in the first hours after the birth of the child “reasons for”

Quality care

Regarding the ‘reasons for’ that support expectations, that is, what they expect in relation to care in the first moments after the birth of the child, the desire of, in future situations, whether with them or with other mothers, a quality care, being more understood and that professionals pay more attention to their needs. It should be noted that mothers who considered their quality care desired the maintenance of this quality, while others expect improvements related to care by professionals.

May they always continue like this, may they treat other people as they treated me, may they continue like this, because they were wonderful (M28IR).

I hope it stays that way, because it's good like this (M19NR).

I wish a better service, that they listen to what we are feeling, that they look at us, that they see us as human beings (M31NR).

That professionals are always so attentive, I know that there are those who are good and those who aren't, but, anyway, I wish they are always so (M21NR)

Accompaniment in childbirth: desires and challenges

The moment of childbirth is experienced by

mothers as unique and full of feelings and sensations, which generate feelings of happiness, but also fear and anguish, and at this time need to be supported by health professionals. Some mothers represented this moment by referring deficiency in the monitoring and care provided by the professionals, and, given the experience, they wish the professionals to follow the birth closer to the parturient, giving this attention and assistance.

I want professionals to identify women's needs, it was painful, because I saw that many suffered in childbirth, what really touched me, were women in pain and they didn't go to assist them (M5AR).

Regarding childbirth, I hope that professionals will be smarter than normal childbirth, because some women need help, they can't do it alone (M3AR).

I hope that after the birth the professionals give full attention, because the mother knows nothing, because with me when my son cried the first time on my lap I didn't know what to do (M11AR).

DISCUSSION

Mothers experienced, in the first hours after the birth of their child, everyday experience in the social world. This was observed in the reports of their experience related to the birth of the baby, care in rooming-in, guidelines regarding the process of breastfeeding and follow-up after discharge. For Schütz, this is configured as the scenario of human interaction in which social actions occur⁽⁹⁾.

Some participants, in the “reasons why”, attributed experience, moments of satisfaction, but others, moments of suffering. The birth of a child requires an adequate environment and that communication occurs between parents and professionals, building a face-to-face relationship, that is, allowing both to perceive and provide genuine exchange between themselves and between the people involved (mothers, family members and professionals) thus providing that care is guaranteed⁽⁹⁾.

It is known that childbirth and postpartum are unique moments for each woman, and are characterized by numerous changes, whether

biological, social or psychological. The human being lives in a world of intersubjectivity, of unequal social relations and in a universe of meanings that are interpreted, and guide the performance of actions. Thus, it is relevant that health actions, such as the provision of comprehensive care during all these moments, offer support not only to the physiological aspects, but also considering the biopsychosocial aspects, taking into account the experience, the understanding that these mothers have of themselves and the events related to this, covering all their subjectivity, thus leading to improvement in the quality of care^(9,10,13).

The care that must occur in the first hour of life, in many of the mothers' speeches, did not happen as recommended. In this sense, the absence of reciprocity of intentions in this relationship occurred between those who take care (health professional) and those who require care (mother/child dyad), this limitation is due to the non-compliance of maternal assistance guided by the guidelines of public health care policies. Thus, it is important that such care is subsidized in these guidelines, in which, through the intersubjectivity of those involved, a reciprocal relationship of intentions between them is structured, contributing to development and higher quality of care⁽⁹⁾.

Skin-to-skin contact in the delivery room should only be postponed in situations where the baby was born less than 37 weeks of gestational age or is clinically unstable⁽¹⁴⁾. However, for many mothers, the reasons reported for contact not having occurred immediately were the way of birth (cesarean) and the need for routine procedures, regardless of having been considered in the gestational period as usual, intermediate or high risk.

It is essential that routine procedures are postponed in the first hours of life, increasing and enabling greater interaction between mother and child. In this study, it was observed in maternal reports that the first contact was often also interrupted to perform hygiene of the NB, as a bath. This procedure should also be avoided, being recommended to be performed 24 hours after birth, not early removing the caseous vertex, preventing neonatal hypothermia, better adaptation of the baby to

the extrauterine environment, in addition to contributing to skin-to-skin contact, increasing the success of breastfeeding and mother-baby bonding⁽¹⁵⁻¹⁷⁾.

It should be noted that some participants had different types of experience, having the opportunity to make skin-to-skin contact immediately after birth, with the onset of breastfeeding. Other mothers reported that their children had complications at birth, requiring referral to specialized units.

The assistance received by some mothers in the rooming-in was characterized as moments of learning, since they received guidance, especially regarding the care of their child. It was at this time that the professionals helped the mothers to perform the first care of the baby, thus favoring uninterrupted creation and development of the stock of knowledge, both of this mother and the professional, a face to face relationship, through intersubjectivity⁽⁹⁾. The rooming-in aims at the closer integration of the mother and infant child, contributing to the establishment of a favorable affective relationship from birth, enabling moments of learning for the mother, developing skills and providing emotional security regarding baby care, encouraging breastfeeding, reducing the incidence of cross-hospital infections and allowing the health team to better integrate with the family^(18,19).

In contrast, some mothers stated that they were not guided and assisted, thus not having the development and structuring of their knowledge stock, which is given through the experience and theoretical-practical learning about a given fact, allowing interpretations about what happened, generating familiarity to the event in question⁽⁹⁾.

One of the guidelines most emphasized by mothers was related to breastfeeding. The first moments of attempted breastfeeding can generate stress and impotence, and the professional should support it, promote breastfeeding and empowerment of this mother. Breastfeeding brings numerous benefits to the mother-child dyad, thus, the knowledge of professionals regarding guidelines for the promotion of breastfeeding requires a close look, since these nursing mothers need information and guidance on the process of

breastfeeding, which can influence the success of exclusive breastfeeding to NB⁽²⁰⁾.

In the postpartum period, in rooming-in, it is indispensable that teams are constantly evaluating and reorienting care, maintaining and ensuring its quality, so that it is performed properly, avoiding risk for both NB and mother and thus empowering the family for home care and, consequently, preparing this mother for discharge⁽⁵⁾.

The lack of communication was referred to as a reason for dissatisfaction, and often brings impacts that mark the experience of those involved. Communication between professionals and patients is directly linked to the quality of care, and the connection between them is essential. Thus, some situations and barriers can interfere in this process, such as the use of technical language and lack of empathy, which are the main impediments to their effectiveness, being essential to observe them in order to avoid the existence of interference, seeking and bringing greater quality and satisfaction to the care provided, since good communication is necessary to ensure that adversity does not interfere with care⁽²¹⁾.

Communication is connected to assistance, and therefore it is used as an instrument for the work of professionals, based on all the knowledge acquired by this professional, through their knowledge and experience. This communication becomes effective and achieves its objective from the moment the other receives and identifies the meaning intended by the sender, enabling the development of an intercommunication between both, thus generating a two-way transmission, where there is authentic response and exchange, benefiting and qualifying the assistance also for patient safety^(9,22,23).

The experience of mothers with the process of discharge from maternity services was referred to as a moment of many orientations, mainly related to services that should maintain follow-up, such as scheduling appointments in the UBS and need for immunizations. This process of guidance and care should not occur only at a specific time, that is, only on the day they were released to their homes, but throughout their hospitalization period, from the first guidelines on admission. This

reciprocity of intentions between the caregivers (the professionals) and the caregivers (the mother and child binomial) is essential for the process of NB care not only in the rooming-in, but also in the primary care services⁽²⁴⁾.

At the time of discharge, professionals should reinforce and provide guidance regarding maternal and child care that should be performed at home, as well as ensure continuity of care in primary care. The counter-referral should occur from maternity hospitals to the BHU, but in the services participating in this study only the usual and intermediate risk maternity performs, through e-mail, the family reference to the BHU. High-risk maternity carries out the reference through a printed document, which the family must take to the BHU. Thus, it is necessary that the professional is trained in order to contribute to the construction of their knowledge stock, thus performing guidelines to the family, reinforcing the importance of seeking health services that should maintain the care segment.

Thus the “reasons for”, that is, guide future action, when mothers were asked about expectations with care in the first hours after birth, mothers expect quality care, with professionals who pay attention to their demands.

In cases where maternal experience was reflected positively, future desires were related to the maintenance and permanence of the same care received. In this context, the importance of performing adequate professional care is determinant for maternal satisfaction and well-being⁽²⁵⁾.

However, in the situations in which they experienced and met their expectations, they want improvements in the care provided, as well as the follow-up to childbirth, referring to the desire that professionals are present, giving help and attention during the process of childbirth “reasons for”.

Childbirth is a time when women are surrounded by feelings and sensations and it is essential that the professional is present, providing guidance and informing about the care that will be performed. During the period of delivery and birth, the parturient woman needs to feel welcomed, and thus enable information, stimulate the participation of the

companion, offer active listening, provide a welcoming environment, answer questions and support is a fundamental role that should be played by health professionals⁽²⁶⁾.

The absence of a face-to-face relationship, the development of an intersubjectivity and reciprocity of intentions between the mother who wishes to be cared for and the professional who must take care of led some mothers in this study to experience moments of dissatisfaction regarding care in relation to childbirth, the desire for greater proximity, assistance and attention of the professional in the follow-up to childbirth, as well as wishing that the professionals are more attentive to the needs of the parturient woman.

The limitation of this study is that data collection occurred six months after birth, which may have resulted in loss of details of the experience of the participating mothers. However, it should be noted that they, in general, referred that these moments were very present in their memories, since some were still emotional mainly in the reports that occurred some intercurrent with their children.

As a contribution to the practice of neonatal nursing, understanding the “reasons why” and the “reasons for” in the care of the parturient

woman and her child, in addition to the meanings about nursing care, can subsidize the quality of care, resulting in best practices in care.

FINAL THOUGHTS

The first hours of a child's life can lead to innumerable feelings when a woman perceives herself as a mother and the main caregiver of the child. In relation to the ‘reasons why’, the experience of birth occurred with moments of interaction and contact with the NB, but also of little contact and distancing due to the performance of procedures and intercurrents.

In the rooming-in, they experienced moments of learning, caring for the baby, support and encouragement of breastfeeding, also verbalized the absence of the professional, generating desires and expectations “reasons for” improving the quality of care, professionals are more attentive to their needs, and make themselves present. Given the assistance received during their stay in maternity hospitals, mothers with positive and negative experience reported being satisfied with the care received.

CUIDADO AO RECÉM-NASCIDO EM MATERNIDADES PÚBLICAS ASSISTIDOS PELO PROGRAMA REDE MÃE PARANAENSE: O VIVIDO MATERNO

RESUMO

Objetivo: compreender a vivência materna frente à assistência ao recém-nascido em maternidades públicas.

Método: estudo qualitativo, fenomenológico, fundamentado no referencial teórico-metodológico de Alfred Schütz. Os dados foram coletados com uma amostra de 30 mães de recém-nascidos, por meio de entrevista semiestruturada, no período de fevereiro a julho de 2018. As entrevistas foram realizadas no domicílio das mães.

Resultado: As mães vivenciaram momentos de alegria, mas também de sofrimento em relação ao nascimento e cuidado de seus filhos nas primeiras horas de vida, e devido a essas vivências, expectativas quanto à assistência para algumas foram além do esperado e para outras ocasionaram frustração como pode-se observar nas duas categorias que emergiram de seus relatos: A primeira referente a experiência vivida, ou seja, os “motivos por que”: Vivenciando as primeiras horas de vida do filho nos serviços de maternidade (Sala de Parto: aproximações e distanciamento do contato; Alojamento conjunto: (re) aprendendo o cuidado com o bebê; Apoio a amamentação; Falta de comunicação, Orientações de alta e Gratidão frente a assistência recebida), a segunda categoria traz as expectativas, os “motivos para”: O que espera da assistência nas primeiras horas após o nascimento do filho (Assistência de qualidade e Acompanhamento no parto: desejos e desafios). **Considerações finais:** a vivência do nascimento foi tida com momentos de interação e contato com o recém-nascido, porém, também de pouco contato devido realização de procedimentos e intercorrências. As mães vivenciaram momentos de aprendizados e também verbalizaram ausência do profissional, gerando desejos e expectativas de melhora da qualidade da assistência.

Keywords: Recém-Nascido. Maternidades. Saúde Materno-Infantil. Enfermagem Neonatal. Cuidados de Enfermagem.

CUIDADO AL RECIÉN NACIDO EN MATERNIDADES PÚBLICAS ASISTIDO POR EL PROGRAMA REDEMÃE PARANAENSE: LA EXPERIENCIA MATERNA

RESUMEN

Objetivo: compreender a vivência materna frente a la asistencia al recién nacido en maternidades públicas. **Método:** estudio cualitativo, fenomenológico, fundamentado en el referencial teórico-metodológico de Alfred Schütz. Los datos fueron recolectados con una muestra de 30 madres de recién nacidos, por medio de entrevista semiestructurada, en el período de febrero a julio de 2018. Las entrevistas se realizaron en el domicilio de las madres. **Resultado:** las madres experimentaron momentos de alegría, pero también de sufrimiento respecto al nacimiento y cuidado a sus hijos en las primeras horas de vida, y debido a esas vivencias, las expectativas en cuanto a la asistencia para algunas fueron más allá de lo esperado y para otras ocasionaron frustración como se puede observar en las dos categorías que surgieron de sus relatos: La primera referente a la experiencia vivida, o sea, los "motivos por los que": Viviendo las primeras horas de vida del hijo en el sector de la maternidad (Sala de Parto: aproximaciones y distanciamiento del contacto; Alojamiento conjunto: (re)aprendiendo el cuidado con el bebé; Apoyo a la lactancia; Falta de comunicación, Orientaciones del alta y Gratitud frente a la asistencia recibida), la segunda categoría trae las expectativas, los "motivos para": Qué espera de la asistencia en las primeras horas después del nacimiento del hijo (Asistencia de calidad y Acompañamiento en el parto: deseos y desafíos). **Consideraciones finales:** la experiencia del nacimiento fue presentada con momentos de interacción y contacto con el recién nacido, sin embargo, también de poco contacto debido a la realización de procedimientos y complicaciones. Las madres experimentaron momentos de aprendizaje y también verbalizaron ausencia del profesional, generando deseos y expectativas de mejora de la calidad de la asistencia.

Palabras clave: Recién Nacido. Maternidades. Salud Materno-Infantil. Enfermería Neonatal. Cuidados de Enfermería.

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Corresponding author: Adriana Valongo Zani. Av. Robert Koch, 60 - Operária, Londrina - PR, 86038-440, Brasil. Email: adrianazanienf@gmail.com.

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