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Narratives on the experience of being a high-risk puerperal woman

Narrativas sobre a experiência de ser puérpera de alto risco

Narrativas sobre la experiencia de ser puérpera de alto riesgo

Ariane Thaise Frello Roque[1]
Telma Elisa Carraro[2]

1. University of Alberta no Canadá. Edmonton - Alberta - Canada.
2. Universidade Federal de Santa Catarina. Joinville - SC, Brazil.

Abstract

Objective: When the postpartum occurs concomitantly with the newborn hospitalization, it leads to postpartum women to become a companion in the Neonatal Unit, which may influence these women's vital power. This situation characterizes the High-Risk Puerperium. This study aims at learning the experience of being a high-risk puerperal woman. **Methods:** This is a qualitative narrative study based on Florence Nightingale's theory, conducted at a public institution in southern Brazil from January to March 2010. The study subjects were seven high-risk puerperal women older than 18 years of age, and in this article we presented the experience a high-risk puerperal woman who wished to participate in the study and signed the Informed Consent Form. **Results:** The results demonstrate the mixed feelings faced by the high-risk mother. **Conclusion:** It is important to expand the term high-risk puerperium in health programs, in order to address the nursing care for the mothers who are with their babies in the neonatal unit.

Keywords: Postpartum period; Emotions; Nursing Care; Intensive Care Neonatal Units.

Resumo

Objetivo: Quando o puerpério ocorre concomitantemente à hospitalização do recém-nascido, leva a puérpera a tornar-se acompanhante na Unidade Neonatal, o que pode influenciar seu poder vital conceituando-se o Puerpério de Alto Risco. O objetivo deste estudo foi conhecer a experiência de ser puérpera de alto risco. **Métodos:** Narrativo com abordagem qualitativa, sustentado em Florence Nightingale. Realizado em uma instituição pública do sul do Brasil, de janeiro a março de 2010, foram sujeitos da pesquisa sete puérperas de alto risco acima de 18 anos, sendo neste recorte apresentado a experiência de uma puérpera de alto risco que desejou participar e assinou o Termo de Consentimento Livre e Esclarecido. **Resultados:** Os resultados demonstram a mescla de sentimentos enfrentada pela puérpera de alto risco. **Conclusão:** Sendo importante a ampliação do termo Puerpério de Alto Risco nos programas de saúde, a fim de contemplar o cuidado de enfermagem específico às puérperas que estão com seus bebês na unidade neonatal.

Palavras-chave: Período Pós-Parto; Emoções; Cuidados de Enfermagem; Unidades de Terapia Intensiva Neonatal.

Resumen

Objetivo: Cuando el puerperio se produce de forma concomitante con la hospitalización del recién-nacido en la Unidad de Neonatología, puede influir en poder vital de la mujer conceptuándose en Puerperio de Alto Riesgo. Ese estudio objetiva conocer la experiencia de ser una puérpera de alto riesgo. **Métodos:** Narrativo, cualitativo, basado en Florence Nightingale, realizado en una institución pública del Sur de Brasil, de enero a marzo 2010. Participaron siete puérperas de alto riesgo mayores de 18 años. En este artículo se presenta la experiencia de una mujer que firmó el Término de Consentimiento Libre y Esclarecido. **Resultados:** Los resultados demuestran los sentimientos encontrados en la puérpera de alto riesgo. **Conclusión:** Es importante la expansión de la definición de Puerperio de Alto Riesgo para los programas de salud, con el fin de mejorar los cuidados de enfermería para las madres que están con sus bebés en la unidad neonatal.

Palabras-clave: Período Postparto; Emociones; Atención de Enfermería; Unidades de Cuidado Intensivo Neonatal.

Corresponding author:
Ariane Thaise Frello Roque.
E-mail: arianethaise@yahoo.com.br

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INTRODUCTION

The postpartum period involves women in a mix of feelings and changes in daily routine. When this period occurs concurrently with the newborn hospitalization, it leads the postpartum woman to become companion in the neonatal unit, so she stays away from the rest of the family and lives moments of apprehension about the baby. This situation that weakens her, endangering her health, since her body is in restoration process, leads her to alternate between the care of her home and her baby in the hospital, which may influence her Vital Power - feature that this study refers to as High-Risk Puerperium.

In 2011, the Ministry of Health launched the *Rede Cegonha* (Stork Network), which was regulated by Ordinance Nº 1459 in 24 June 2011, and aims at expanding access and improving prenatal care, delivery care, postpartum care and care to children of up to 24 months of life[1]. This strategy has the objective to prioritize actions related to best practices of care during labor and birth, from the reorganization of health care, based on scientific evidence and focused on the welfare of postpartum women, children, fathers and families. One of the proposed measures is the creation of a new place for maternal and child health care, called Baby, Pregnant and Postpartum Women Homes, which aim to look after, among other populations, "mothers with baby hospitalized in the Neonatal Intensive Care Unit of health service and/or in need of information, guidance and training in special care with their babies"[1:14]. The Ministry of Health does not provide a specific definition for the term high-risk postpartum, only citing that "the Homes should be linked to maternity or referral hospital in pregnancy, labor, birth and high-risk postpartum"[1:14]. However, it is known that this term is commonly related to the post-partum period after the high-risk pregnancy.

This study proposes an expanded definition of high-risk puerperium, because "even though a woman has not experienced a high-risk pregnancy, she could experience a high risk--puerperium if her care needs are not met"[2:120].

The postpartum period is an important period for women, as they go through different types of modifications that interfere in all spheres of their lives, requiring new adjustments, not only in the physical domain but also in the psychosocial domain, which reflects in each one of them, fully, as a woman and mother[3].

In this study, the conceptual framework covers the concepts of Vital Power, Human Being, Restorative Process, Care Environment and Nursing Care, based on the theoretical framework of the founder of the Modern Nursing[4-6].

The term Vital Power has not been defined; it only pointed out that the human being possesses that power. It appears, then, that the vital power is the life force of the human being, that when positively mobilized, facilitates the restoration of health. Otherwise, it contributes to the worsening of the disease. This is influenced by factors such as: ventilation, noise, lighting, cleaning. But Florence goes beyond the physical environment to worry about the quality of care provided to humans, pointing their needs as: distractions from visual stimuli, pleasant visits, contact with nature, crafts and others. Thus, nursing, in caring for that human being, must assist them in finding "the best possible conditions so that nature can act on them"[6:146]. She also states that the nature had instituted the restorative process[4-6]. This is understood as a process of being healthy, while recovering from the factors that led the person to become sick. This process can be facilitated by using means that strengthen the individual's vital power or it can be delayed when the vital power is weakened.

The human being, in this case, is the high-risk puerperal woman that is exposed to various stressors such as the specific clinical conditions that her child is facing, in addition to the strange environment, strong light, sophisticated equipment and unknown team people, which can affect her psychological state[7]. Amid a different routine and constant dedication to the baby, the postpartum woman leaves the care for herself aside, assuming responsibilities that can overload her and have a negative influence on her recovery.

The environments in which high-risk postpartum women courses and lives are rooming-in, breast accommodation, neonatal unit and the Kangaroo Mother Care method facilities. Breast accommodation was designed to facilitate and encourage the presence of the mother with her child, even when the baby is under intensive care, providing her conditions of rest and nutrition[8]. The Kangaroo Mother Care method facility is a place where a neonatal care strategy is performed, which involves early skin-to-skin contact between mother and baby[9].

In these different care environments, nursing is responsible for guiding postpartum women to find their place in the new environment and in caring for their children, and also for practicing a sensitive and attentive listening through effective and respectful performance, considering their care needs. It is also important to socialize with other mothers who share the same situation, which favors the adaptation to the new routine, as well as coping with difficulties that may arise[8].

In order to break through the biomedical system, there arises the need to transform nursing care throughout the pregnancy and childbirth in a comprehensive and humanized way[10]. This care during the postpartum period, "a period considered risky" needs to be based in the sensitive listening and valuing women, aiming at preventing complications, providing physical and emotional comfort in order to provide tools for postpartum women to care for themselves and their children[11:348].

Focusing attention in a specific and delicate situation as the high-risk postpartum period has became a challenge, as the nursing care are directed towards the newborn and, in some institutions, towards the puerperal woman, since she has experienced a high-risk pregnancy. The mother of the baby hospitalized in a Neonatal Unit only receives guidance on breastfeeding, which will help in the recovery of her child, and on the care for the baby, so that it can be continued at home. What about this woman, how is she? How is she doing, with all these events and feelings, regarding the restorative process after delivery?

These concerns guide the development of this study, that sought to hear the stories of these high-risk mothers to understand them in their care needs. We sought to answer the core question: How does the high-risk postpartum woman experience the neonatal hospital stay of her baby? This study aimed to evaluate the experience of being a high-risk postpartum woman during neonatal hospital care of her baby.

METHOD

This is a narrative study, based on Florence Nightingale's theory, with a qualitative approach. It was held in Florianopolis in a public institution from the South region of Brazil that meets 100% the Unified Health System (SUS), from January to March 2010, derived from a fragment of a doctoral thesis in nursing.

The research participants were seven mothers older than 18 years of age who were with their babies in the Neonatal Unit, who wished to participate in the study and signed an Informed Consent Form. The approach occurred in casual encounters in breast accommodation, and from conversations with mothers who were there; the researcher presented herself and invited each to participate in the study, scheduling time and place to conduct the interview. The interviews took place in shift rooms of the rooming-in or in the Kangaroo Mother Care visiting room, since these places are quiet, which enabled the development of interviews without interruption. Data were collected through narrative interviews, which were recorded and then transcribed. Generating questions were: "Tell me your story from birth until now and how did you feel? How do you realize the nursing care with you?" We ended data collection due to saturation, since data were starting to be repetitive. To preserve the identity of the subjects, we used the letter P of postpartum, followed by numbers from one to seven.

The narrative interview, the one that allows storytelling, was the data collection method; it followed in the steps "Preparation; Initiation; Central Narrative Point; Questions Phase and Conclusive Speech"[12:97].

The treatment and analysis of data were based on Fritz Schütze's tecniques,[1] who, in addition to presenting the narrative interview proposal, identifies six phases to systematize data. The narrative interview was operationalized[12] and applied by other authors[13]. These phases are: Phase 1: Detailed Transcription of verbal material. Phase 2: Dividing of text in indexed materials (it has concrete reference to "who did what, when, where and why") and non-indexed materials (they express values, judgments and all forms of life wisdom). Phase 3: Using the indexed components of the text to analyze the ordering of events for each individual, i.e., the trajectories. Phase 4: The non-indexed dimensions of the text are investigated as "analysis of knowledge." Phase 5: Grouping and comparison of individual trajectories. Phase 6: Comparison of cases within the context with the identification of individual trajectories. Similarities are set for the establishment of collective trajectories[12].

Regarding the ethical aspects, before the start of the study we obtained informed consent of the participant institution and approval by the Research Ethics Committee of the UFSC, under Nº 1132/2010.

RESULTS AND DISCUSSIONS

In this paper we explore the narrative of the participant P5 and her indexed and non-indexed propositions in order to signify the experience of being high-risk postpartum women.

Indexed propositions: Order of events

At this phase of data analysis, we used all indexed components of the text to sort the events of the individual in order to know their history and their trajectory[13].

P5, married, 35 years old, Catholic, lives with her husband and a 4-year-old son. She has completed high school and works as administrative assistant in a company. She had a miscarriage and two C-sections. In her latest C-section her baby was born with 30 weeks and 2 days of gestation, weighing 900 grams and was transferred to the Neonatal Unit. All data on admission, her health and her baby's health were informed by the puerperal woman.

The interview was conducted in the environment of Kangaroo Mother Care method while the baby was under the P5's care the whole period, with the help of the nursing team.

She said she has been hospitalized in the rooming-in for 22 days because there was too little fetal movement and her pregnancy was at high risk, due to preeclampsia. This period included the Christmas holiday, during which she received discharge to spend it with her family.

> *[...] During Christmas, before I have [the baby], my God, I went home, I was discharged by the doctor to spend Christmas Eve at home, but it wasn't Christmas to me, you know, I was sick, I could not do it, you know [...] (P5).*

The health team, realizing that the fetus had not won more weight, chose to terminate the pregnancy.

> *[...] then he said we could not take more risks because of my blood pressure and everything. So, at the beginning I was a little scared because I did not want it, I wanted to hold pregnancy a little longer, but [the baby] was not gaining weight [...] (P5).*

After being discharged, P5 alternated her time between her home and the rooming-in.

> *[...] thank God the baby did not need to stay in the incubator, did not need oxygen until now, so I got calmer. But it is complicated when you get discharged and you can't take your baby home [...] I was very sad but I started staying*

here [in the rooming-in], there is nothing to complain about here, sometimes I had to go home because it was too crowded. I would go home and come back the next day, but I never stopped being near my daughter [...] (P5).

Non-indexed propositions: Reflections on events

The non-indexed dimensions of the text are investigated as "analysis of knowledge." They may be classified in descriptive dimensions (feelings and experiences generated by events, expressing values) and argumentative dimensions (which is not accepted peacefully in history and reflections arising from events)[12]. Dimensions are presented and analyzed, which brings out the production of knowledge[13].

Descriptive Dimensions

The participant describes apprehensive moments when learning that her baby would be born prematurely:

[...] so this scared me a little, I cried a lot, but thank God the birth went well, I was more scared about her (baby), thinking she was going to be born very sick because she was premature [...] thank God she came and did not need to be in the incubator, did not need oxygen until now, so I got calmer [...] (P5).

The moment of finding that the child will be born prematurely makes the mother suffer and go through situations of fear, pain and sadness, since the hospitalization of the newborn is permeated by many expectations[9]. Counseling patients about their health condition and about the events around them is a way to preserve them. On the other hand, "apprehension, uncertainty, waiting, expectation and fear of surprise bring more harm to the patient than any physical effort"[6:49]. Thus, one can see that P5 showed great anxiety when discovering about prematurity, however, when informed of the clinical picture of the baby, she could calm down. Since she was experiencing the birth process, enhancing her psychological status during care is a way to provide a satisfactory recovery.

The time of discharge is highlighted as a difficult situation: going home without the baby:

[...] it is complicated when you get discharged and you can't take your baby home, and it was during New Year's Eve, so it was a shock for us and I was very sad [...] (P5).

Finding that the baby will have to remain hospitalized in neonatal unit causes suffering to the postpartum women, who, since the immediate postpartum period, is far from her child and also is discharged and goes home alone[14]. This moment is critical, because the separation is materialized when the mother gets home and realizes that all the preparation to receive the baby, the expectations for the return to home were delayed. These feelings of sadness, mixed with worry and uncertainty regarding the baby's health, can be potentialized when the puerperal woman is far, without news. This weakens her Vital Power and has a negative influence on her recovery process, which is the puerperium.

Vital Power is referred as the life force necessary for humans to stay healthy and act against diseases[6]. The postpartum woman describes how she found ways to strengthen her Vital Power during the hospital stay:

[...] I try to stay close to my family, my room friends, because it's very complicated. And in the New Year's Eve it's the same thing, leaving my daughter here and going home, I have no mood to party, so I just wanted to cry, cry, cry then my mother said to me "You have to take care because otherwise you will get depressed" and in fact I saw I was getting depressed, because I cried about everything and ... then, staying in the [rooming-in] living with the other mothers, talking with them, I already feel slightly better [...] (P5).

Among these precautions, we highlight the support network of the family and especially of other women facing premature birth during the postpartum period. This recognition of feelings in other people makes them feel they are not alone and they realize that they can lean on other women during this trajectory. Thus there is an empowerment of the vital power from the encounter with the other, with the experience of feelings of solidarity and the action of sharing of experiences. It is understood that "mothers, knowledgeable of the scale of suffering that involves them, build a network of solidarity and friendship with each other, motivated by the common needs and experiences"[8:78]. The experience of nursing staff also contributes to strengthening the vital power when they share their perception, guiding puerperal women on the clinical picture of baby.

Asked about the nursing care provided to her during the times when she was in hospital, P5 reports:

[...] oh! They are very careful in both the rooming-in and when I was hospitalized with [the baby] in the neonatal unit, they are also well careful. Since I was in the rooming-in they have always thought of me and my daughter, thank God they cared so much of me and of her. That's why we're almost out today, they care so much, there is no explanation [...] (P5).

It is important that the mother and the newborn receive care, and that they are free to express their feelings related to this critical stage[15]. It is noticed that this woman values the care provided to her baby, and when she sees the baby receiving nursing care, she feels like she is being care of, too. As the author reinforces, the nursing care can have great influence in determining the disease consequences[5], which in this case influences the baby and the high-risk postpartum woman's recovery process.

When the babies reach a stable weight and no longer require oxygen support, they go to the Kangaroo Mother Care accommodations, where they remain 24 hours with their mothers and with support from the nursing staff. During their stay in Kangaroo Care, P5 noticed care with her rest and with well-being of her baby:

> *I have nothing to complain about the care provided by the nursing team. My daughter cries a lot, she cried a lot last night, then a nurse came in, took my daughter and said, "No mom, get some rest and we will take care a little bit of your girl" and she took her, so I have nothing to complain about it, I just have to thank them. So I was a little relieved because here in hospital we get all day living for the baby, so she wants to switch day for the night. When the night comes, I want to rest and she is crying, so I get desperate. All mothers are sleeping; the other babies are calmer, oh! Thank God, I thank her so much. Then she brought her, my daughter was calmer, it was time for breastfeeding, she nursed and slept again. Then I managed to rest a lot. I was very calm because I know I do not need to be worried because they are very careful. (P5).*

Sleep is important in patient's recovery and one must be attentive to noise that can disrupt sleep or even make patients completely lose sleep[6]. It can be seen that, in this case, the source of noise was the premature baby, who needed care that could be delivered by nurses, prioritizing the rest of the puerperal woman, who needs to restore her vital power to take care of her child and herself. The narrative demonstrates the sensitive care of the nursing staff, who realized her need and through that action prioritized her welfare, taking care of both the baby as the high-risk postpartum woman.

Care for the baby is highlighted as if it was a care to high-risk postpartum women. Knowing that the baby is being taken care comfort mothers, and they translate it as a care for themselves, which makes nursing care be praised. When asked about the nursing care aimed at her, P5, this high-risk postpartum woman, reports:

> *When we meet they say: 'Hi, how is your baby?' But there was no care for me. Of course, they know us; there is an understanding between us and them, but they didn't provide care to me, no (P5).*

It is noticed that the newborns' mothers expected a specific care, focused on their needs, that goes beyond the limits of a hallway conversation. Women in high-risk puerperium need care after delivery. For the achievement of this treatment, a specific nursing staff is required, grounded in a focused care plan for high-risk puerperium, making the puerperal mother the focus of care and not only a companion of the baby hospitalized in the neonatal unit.

Having a baby hospitalized in the neonatal unit is a time of family crisis, especially for women in the postpartum period. Because of this, mothers needs to be "assisted by nursing professionals equipped with elements that enable the practice of a singular care, focused on beliefs, values, and lifestyles of every woman and their families"[16].

The support of the entire healthcare team is highlighted by P5:

> *[...] from nursing care to the care provided by the social worker and the psychologist, from the moment I heard it was going to terminate the pregnancy, they already came to me, told me how it was, took me into the neonatal unit and showed me. Every day somebody of the team would come here and tell me: "Hey today we are going to see your girl"; they were always there for me, you know. And regarding the nurses, I have nothing to complain about all procedures, either. The social worker also helped me a lot [...] from the social worker to the psychologist and nurses, I have nothing to complain about them [...] (P5).*

The great essence of good organization in teamwork is that each professional plays their role in order to help and does not hide their work from other team members[5]. The multidisciplinary care in the high-risk puerperium is essential and requires the commitment of everyone in the health team in order to provide care to postpartum women during the stay of their child in the neonatal unit, focusing on strengthening the vital power of the puerperal woman.

Focusing not only on the child, but on the puerperal woman and her family is a necessary care that can be expressed in guidelines and news about the baby, which minimizes the concerns of postpartum women, as well as establishes a relationship of trust with the multidisciplinary team[15]. Considering the particularity of each puerperal woman through a sensitive and attentive listening enables health professionals to an effective and respectful performance, considering these women's individual care needs[8].

Argumentative Dimensions

The interviewee highlights the importance of establishing links within the hospital to support her during the hospital stay of her baby:

> *[...] I arrived here together with P4, so she is already a companion for me, I could not be alone here, that's the problem: when you are, you get depressed [...] this is so truth that sometimes nurse enters in the room and I begin to and cry because I get very emotional [...] (P5).*

The daily contact with the nursing staff makes P5 feels free to talk in times of anxiety, as well as with their colleagues, other high-risk mothers that have been with her since admission in rooming-in.

The establishment of helping relationships allows postpartum women to comfort themselves mutually in face of unexpected and bad events, seeking to join forces to deal with the difficulties. Interaction with healthcare professionals is also an important support, since they feel understood in their needs[8]. Thus, the nurse needs to recognize the postpartum women's emotional needs, because while some women may prefer to suffer alone, others may want to be subject of constant care and would like to always have someone with them. From the observation of these peculiarities, their needs will be met by providing special care[6].

Reflecting on her experiences, the interviewee perceived positive and negative situations and the best to deal with them. Based on this reflection, she advised and supported the other mothers:

> *[...] so, I talk to women that are feeling sad, then I expose my situation, talk about my experience, there's also this girl from [another city], she needing us now, so I talk a lot to her. So this is the secret, it's all about talking and don't isolate yourself. I say this from my own experience, because I tried to isolate myself and it hurt me a lot [...] (P5).*

The hospitalized patient feels better to be able to talk openly about their situation, expressing their desires and aspirations without judgment[6]. The high-risk postpartum women have the possibility to relate to mothers who are in the same situation and their can share their feelings and advices, supporting each other.

With anguish, the puerperal woman talks about the news about her baby's health status:

> *[...] the relationship is like this…talking in a meeting with mothers the only complaint is that they do not speak to you directly what they are going to do, for example a procedure, an examination, an x-ray. For instance, yesterday she did an ultrasound and I do not know what the result of the ultrasound is [...] (P5).*

In the academic training of health professionals, learning is mostly focused in providing physical care and guidance to patients, without emphasis on the practice of therapeutic listening. Keeping the family informed about the changes in the clinical picture is as important as the search for clinical recovery itself[17]. Whereas the mother of the newborn admitted to the neonatal unit is experiencing the high-risk puerperium, a period marked by the restorative process, nurses should also pay attention to the way that information is passed on, because "irresolution is what most upsets the sick people"[6:47]. So caring for high-risk postpartum women involves keeping them informed about their health status, as well as their children's health status, eliminating feelings of indecision and anxiety.

This study emphasizes the situations in which the high-risk postpartum woman did not peacefully accepted the termination of pregnancy, so that the experience of being a mother during neonatal hospitalization leads her to deal with their emotions, fear of depression, uncertainty as to the condition of her baby's health and miscommunication with professionals, showing the negative impact on her vital power during the restorative process that is intrinsic to the puerperium. Sharing the experience of prematurity with other mothers who are going through the same, the support of the health team and the comfort found in nursing care through a conversation, a shoulder, the guidance on the clinical picture and the proper care directed to the baby were configured as acts that empowered her vital power.

The high-risk postpartum women of this study points out that during the neonatal hospitalization nursing and health care team, by providing care to her baby, took care of the mother herself. The neonatal unit staff expands their care to look at the baby's mother when she demonstrates her need, during sensitive moments in face of the strong emotional impact on prematurity. However, the postpartum woman could not identify a nursing care directed only to her health needs.

FINAL CONSIDERATIONS

New research on the care needs of high-risk mothers has greatly contributed with these mothers, who are generally treated as companions of hospitalized children. It is important to know the perspective of nursing professionals about dealing with high-risk mothers and about the care needs perceived by them in order to create a feasible plan of care and that meets the possibilities of professionals.

As for the limitations of this study, we can mention the conduction of interviews in the hospital setting, which can inhibit the puerperal woman to express all her feelings and opinions, fearing that this may influence in the care provided to her child and to herself.

The proposal of implementing Stork Network Program throughout the country brings the possibility of a care directed to this postpartum woman, strengthening the care network in the stages of pregnancy, childbirth and high-risk puerperium. The fact that the term high-risk postpartum is currently linked to high-risk pregnancy is a conceptual limitation, since from the perspective of health professionals, there is no specific care for postpartum women who had a normal pregnancy, but who are facing neonatal hospitalization of their babies. Thus, this research provides to health professionals in general and to nurses, specifically, expansion of the definition of this concept so that care is implemented in all health institutions that have neonatal unit, including accommodation and a nursing care plan focused on these high-risk mothers. This would enable that care occurs throughout neonatal hospitalization, covering all physical and psychological needs inherent to the high-risk postpartum.

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