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The implementation of a home visits program focused on parenting: an experience report*

A implementação de um programa de visitas domiciliárias com foco na parentalidade: um relato de experiência

La implantación de un programa de visitas domiciliarias con enfoque en la parentalidad: un relato de experiencia

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ABSTRACT

Objective: To report the experience of implementing Home Visits as part of the Young Mothers Caregiver Program. **Method:** The program focuses on the mother-child relationship as an object of care for developing parenting using the attachment theory, the self-efficacy theory and the bioecological theory as references. The construction of this program was centered on materials of international visitation programs, based on the translation of the material, elaboration and validation of the theoretical content. **Results:** The home visits performed by the nurses lasted an average of 1 hour, where issues related to health care, environmental health, life project, parenting, family and social network, in addition to the adolescents' demands were discussed. It was shown that nurses encountered difficulties in implementing the program. **Conclusion:** By adopting Home Visits as a care tool with a focus on parenting, the experience of implementing the program proved to be an innovative technology, with great potential and relevance for promoting adolescent care and child development.

DESCRIPTORS

House Calls; Family; Adolescent; Child Development; Pediatric Nursing; Family Nursing.

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INTRODUCTION

Several initiatives of Home Visiting (HV) programs have been implemented with the purpose of promoting child development and care. Most of these programs prioritize families and mothers with greater social and economic vulnerability, thus representing an important mechanism for equity[1]. Home visiting is chosen as an intervention strategy since it is a powerful tool for identifying the health needs that vulnerable families with young children face[2-3].

The *Nurse Family Partnership* (NFP) is an example of this type of health intervention which has offered many theoretical and practical contributions to the results of these Home Visiting programs in qualifying mother-child interaction and in strengthening the family social protection network. Based on the assessment interview, the NFP has first-time pregnant mothers as their target population, seeking to "encourage" these adolescents to engage in responsive care for their babies and to build an autonomous life project for themselves. The results of the research related to NFP implantation demonstrate an improvement in the mother's responsiveness and in the mental, cognitive and social development of children, as well as better insertion of adolescents into society[4].

Another contribution for the effectiveness of HV programs that focuses on "parental" care for child development is the *Minding the Baby* program (MTB)[5], which was developed in the United States and designed by the YALE University School of Nursing. The MTB focuses on building the reflective capacity of mothers so that they can improve the care offered to their babies[5].

Both the NFP and the MTB have in common the fact that they are carried out by nurses, their actions are inserted in the field of health promotion and parental care and they have the cognitive and social development of children as the purpose of their interventions.

Recent studies indicate that developing parents' parenting abilities increases maternal/paternal responsiveness to the child's needs, which will positively impact child development. "Parenting" is understood as the set of activities developed to ensure the survival and development of the child in a safe environment in order to make them more autonomous and prepare them for physical, economic and psychosocial situations that will arise throughout life[6].

The relevance of a care process that aims to construct positive parenting is based on recent discoveries in the field of epigenetics and neurodevelopment, which point to two key aspects in child development: biological processes and the experiences. According to these theories, brain development presents a biological stage and accelerated formation of synapses in the first years of life. This biological development is complemented by everyday experiences; thus, the interaction between bio and environment influences the permanent neuronal structures in the brain[6]. With this, we can deduce that the child development process happens naturally, however it is possible to act in a way that favors this development during early childhood through the family and the experiences that they can provide to the child, and this action is implemented by constructing positive parenting[6].

We point out that undesirable pregnancy in adolescence is a common occurrence, and such circumstance can bring serious maternal and fetal complications, among which we can point out: specific hypertensive disease in pregnancy, prematurity and low birth weight. In addition, the repercussions of early pregnancy in some cases can have impacts beyond the health of the mother and baby, affecting the biopsychosocial dimensions of this dyad, making them vulnerable and compromising their full development[7].

Inspired by the cited experiences and sensitized by the social impact that teenage pregnancy entails, a group of researchers from the School of Nursing and the Institute of Psychiatry of the Universidade de São Paulo created the "Young Mothers Caregivers Home Visiting Program" (*Programa de Visitação Jovens Mães Cuidadoras – PJMC*). This program aims to: promote early childhood development, thus improving health outcomes (in the mother and child); promote sensitive and responsive relationships between the mother and the child (positive parenting); stimulate cognitive and emotional interactions between mothers and babies (attachment); improve the family and social support network; and to improve individual capacities to achieve better insertion in the work and adolescents' life (self-efficacy).

The PJMC was developed to be part of and is being tested and implemented in the study "The effects of the home visiting program for young pregnant women on child development: a pilot study", funded by the *Saving Brains/ Grand Challenges Canada* program. These institutions traditionally provide funding for innovative projects aimed at solving problems that impact the development of children.

Thus, this study had the objective to report the experience of implementing the "Young Mothers Caregiver Home Visiting Program". The theoretical and conceptual bases of the PJMC will be described below, as well as how the program was developed and validated, the experience of its implementation (in the sections of method and results), and aspects that facilitated and made implementing this technology challenging for nursing (in the conclusion item).

METHOD

The PJMC is a technology to be used by nurses, mainly those in Primary Health Care (PHC), which focuses on the mother-child relationship as an object of care, seeking positive parenting or the construction of family care competencies for the child as the goal of this care[3,6]. In Brazil, there are no systematized technologies for "building parental care" to be used by nurses in the PHC, which represents the innovation of the PJMC.

The PJMC implements three major approaches as a theoretical framework to support its care structure, which are: 1) Attachment theory, which recognizes the critical importance of newborn infants developing secure connections with their mothers for their further development[8]; 2) the Self-efficacy Theory, which provides a framework for (home) visiting nurses to understand how women make decisions for themselves and their child[9]; and 3) the Bioecological Theory, which highlights the importance of the mother's social, community and family context in influencing her decisions, behaviors and ways of caring for her children[10]. These theoretical foundations translate into five axes of care: a) health care; b)

environmental health; c) positive parenting; d) social network and family; and e) life project. The care axes of the PJMC should compose and encompass the home visits accomplished.

Construction of the PJMC included three steps: 1) translating the public material relating to the NFP and MTB, as they were the inspiring models for the technological approach; 2) elaborating the structure and theoretical instructional content of the *PJMC* Home Visiting; and 3) validating the PJMC content by experts in the area.

Step 1 was performed by nurses under the supervision of health professionals with recognized experience and knowledge on child development programs such as the NFP and MTB for analyzing the translated material.

Step 2 was carried out through a focus group with participation of a multiprofessional team composed of nurses (4), a pediatrician (1), psychologists (2) and child psychiatrists (2), comprising a total of nine persons. Eight meetings of this research group were conducted to discuss topics related to the home visiting program content such as general guidelines, results, target population, visits schedule, topics to be addressed to pregnant women, puerperal women and mothers, assessment and intervention tools to be used in the HV, actions to be performed during prenatal HV, actions to be performed during puerperal HV and training nurses for HV program testing. The discussions stemming from this focus group considered the aspects to be used in the different phases of early childhood, the relevance, clarity, objectivity, level of complexity and applicability of evaluation and intervention tools.

Step 3 was performed by academic experts in the field of mental health, public health, maternal and child health and those practicing in PHC services. The Delphi technique was used to collect data, using a characterization tool and a 4-point Likert-scale questionnaire which was composed of thematic blocks, and was approved when the agreement was greater than 75%. This step composed the doctoral thesis entitled "Content validation of a home visiting program for the mother-child dyad".

Ethical aspects

It should be emphasized that the research followed the norms of Resolution 466/2012 of the National Health Council, and was approved by the Research Ethics Committee of the Faculty of Medicine of São Paulo, registered under the CAAE number 41573015.0.0000.0065 and with an opinion number 1.397.051/2016.

Structuring the Program

The HVs performed by the nurses are based on premises that serve as guidelines for the approach of mothers, fathers and families, as described in Chart 1.

Chart 1 – Premise, objectives and interventions of the PJMC – São Paulo, SP, Brazil, 2017.

PJMC Premises	Objective	Interventions
Health Care	Support and stimulate maternal actions intended to maintain and improve the mother's and the child's health.	Proper nutrition, use of drugs and alcohol, personal relationships, personal hygiene (mother and baby), most prevalent childhood illnesses, home care, immunization, prevention of accidents and psychomotor development.
Environmental health	Assist mothers to identify, understand and utilize social resources that can help them in the care of their child.	Adequate and safe home, access to education and health services and social support.
Life project	Assist teenager (mothers) to identify goals relevant to their life.	Continuing education, family planning, looking for jobs/work; however, the interventions should always arise from the needs and interests of adolescents to rescue their other social roles.
Parenting Development	Help the teenager (mother) and the baby's father to develop knowledge and skills to support the health and development of the child with confidence.	Actions and educational processes to help mothers and fathers in constructing their roles as father and mother, and working with the mother to help them understand and manage their relationships with others (including close persons), so that they are favorable for the mother and the child's needs.
Health and Social Work	Ensure the access of adolescents to the services and resources guaranteed by the country's public policies to meet their needs and those of the child.	Mapping the social support network of the family.

Although home visits (HV) are based on these assumptions, planning the visits and the care plan to be carried out with each family are developed in a personalized and individualized way by the visiting nurses, taking the difficulties in the daily lives of the adolescents as reference. Therefore, there is a specific and individualized care plan for each adolescent, and their intervention always focuses on strengthening maternal skills for loving and sensitive child care.

The visiting nurse assesses and re-evaluates their interventions regarding health conditions, safety, social network and the adolescent's life course at all times. Thus, the visiting nurse has access to a group of essential subjects for the intervention, however the degree of intensity and frequency of which each will be approached will depend on the decisions they face in the reality they encounter.

In order to guide the content of the HV, a Visitation Protocol was created based on the program's premises and using the manuals for monitoring prenatal, puerperium and child health as reference. The topics covered in the first visit during gestation are: personal identification, socioeconomic data, family and personal history, anamnesis, physical examination and data on the current gestation. Complaints, habits and routines, physical examination, program premises and nursing notes (visitor impressions and plan for future visits) are recorded on subsequent visits. The Perceived General Self-efficacy Scale, the Maternal-Fetal Attachment Scale and the Edinburgh Scale are applied.

In addition to data regarding the labor and delivery, a physical examination of the puerperal women and the baby are also carried out during the puerperium period, and the premises of the program, the Edinburgh Postpartum Depression Scale and the Child Neurological Examination are applied.

Visits between the 2 to 12 month period of the baby's life consist of a complete physical examination, the milestones of child development, feeding and hygiene, program premises, and mother's questions regarding child care.

The PJMC has a team of supervisors composed of a nurse, a psychologist and a graduate student who carry out a weekly clinical supervision with the visiting nurses in order to promote discussion of the cases and to meet the demands related to the adolescent mothers, the child and the family, and together they seek to solve the demand that arise during the supervision.

RESULTS

Implementation of the PJMC

The PJMC began in August of 2015, when first-time pregnant adolescents between 14 and 19 years of age belonging to social classes C, D and E living in areas of social vulnerability in the city of São Paulo/SP, Brazil and accompanied by the Health Units of the western region were selected and agreed to participate in the program. Pregnant adolescents accompanied during high-risk prenatal care, multiparous adolescents, with any comorbidity, or those who had cognitive impairment were excluded from the program. In this step, 40 adolescents were selected to be assisted by the PJMC. The adolescents entered the program at 8 to 16 weeks of gestation and should remain until the child reached 18 months of age, when the intervention would be considered as "concluded".

The visiting schedule proposed by the PJMC has an average of 58 to 63 visits for each adolescent, carried out biweekly. The average number of visits to be performed per period is distributed as follows: during pregnancy – 10 to 15 HV; in the puerperium – 4 to 6; and around 40 HV from the first 2 months to 18 months of the child's life.

The initial proposal of the PJMC had a team of three visiting nurses; however, the team is currently composed of two nurses, one of them since the beginning of the project, and the other joined in for the step of accompanying the adolescents' puerperium period. Despite the importance of the bond between the mother-nurse for the success of the intervention, professional resignations have occurred during the program's implementation.

After the initial selection, the intervention group was composed of 34 adolescents between 14 and 19 years of age, with some losses due to changes of address/city or lack of interest in continuing in the program. The program is currently in the phase of monitoring children from 06 months to 12 months, with a total of 28 adolescents.

The number of HV carried out with the adolescents varied due to their availability to receive the visits and the gestational age at which the follow-up was started. During gestation, the adolescent could receive a maximum of 17 HV, and most of them received only 11 HV due to the baby's birth. In the puerperium period, the majority of adolescents received an average of six visits, which was expected by the program, however some adolescents received a lower number of HV in the puerperium due to lack of adherence to HV.

The gestational and puerperium HV had an average duration of 1 hour, and during that time with the adolescents, the visiting nurses implemented the premises proposed by the PJMC that are included in the home visit protocols, in addition to the demands of the adolescents. A survey of the main issues addressed in the HV premises during gestation and puerperium and the average duration of discussion of the subjects was performed (Chart 2).

Chart 2 – Subjects addressed in each PJMC premise – São Paulo, SP, Brazil, 2017.

SUBJECTS ADDRESSED	DURATION
HEALTH CARE: Vaccination; Sex life; Hygiene; Educational videos about fetal development and gestational age; Labor; Delivery and breastfeeding; Signs and symptoms of pregnancy (fatigue, nausea, urinary tract infection, headache); Diet and physical activity; Sleeping patterns; Weight gain/loss; Use of medicines (paracetamol, ferrous sulfate); Prenatal monitoring; Ultrasonography.	25 minutes
ENVIRONMENTAL HEALTH: Home (cleaning, organization, location, basic sanitation); Material, financial and social resources; Family/domestic routine; Preparing the home for child birth; Prevention of household accidents; Healthy environment for the child's development.	8 minutes
LIFE PROJECT: Resume studies; Attending a college; Living with the child's father; Maintaining a relationship with the child's father; Moving back to the state of origin (Bahia); Moving House; Renovating the House; Work; Baby's routine; Self-efficacy Scale.	11 minutes
PARENTING: Feelings and anxiety of meeting the child; Positive/negative feelings towards pregnancy; Acceptance of pregnancy; Participation of the father with the child; At first taking care of the baby is something abstract; Maternal skills; Attachment; Anxiety and concern about fetal development; Positive feelings with fetal movements; Finding out the gender of the baby; Encouraging touching/caressing the belly and talking to the baby; Anxiety for labor and delivery; Calling the child by its name; Strategies to strengthen mother-baby bond (massage); Videos about fetal development; Placing your needs below the baby's needs and making decisions that provide comfort to the baby.	13 minutes
FAMILY: Family Organization; Acknowledges family collaboration; Having contact with the extended family; Having a relationship with the family and the child's father; Family conflicts; The mother is the main family member; Plans with the baby; Approach with the family; Family influence on pregnancy and relationship with the child's father; Role of each family member in caring for the baby, during labor and of the adolescent; Financial assistance from family members; Father/son of the child; A source of income.	13 minutes
SOCIAL NETWORK: Family members and extended family as a support network; Teenager's mother as a great source of support; Recreational resources in the community; Challenges in using social resources; Lack of support during the prenatal care and ultrasonography; Shyness in seeking for help; Friends as social support; Courses offered in primary school (*Educandário*); Importance of the social network when necessary; Receives support from non-governmental organization; Getting clothes and gifts from your support network; Skills for seeking resources in the community; Keeping circles of "healthy" friends; Contacting the Social Support Reference Center when necessary; Contacts and transportation to the hospital; Support during labor and delivery.	9 minutes

In the beginning, the PJMC found no difficulty in carrying out the HV to the adolescents; on the contrary, they were receptive and welcoming. Visiting nurses were able to get in touch with the adolescences via phone call, 'WhatsApp' messages and/or social networks. The adolescents' families were also receptive, and some were even participative during the HV, which is valued by the PJMC. The babies' fathers also had free access and could participate in the HV as the project understands the importance of the paternal figure's presence for the child's development.

However, some difficulties are currently faced by the PJMC in maintaining the "schedule/number" of HVs proposed by the program, for example, there are cases of mothers who have started working, and HVs are not being performed due to incompatibility/lack of availability. Another difficulty is that most children are already close to turning 12 months old and are being enrolled in day care centers; 18 of the adolescents have their children enrolled in day care centers, and visiting nurses are only able to perform HV with 10 adolescents.

Difficulties of the visiting nurses are related to public transportation, due to the time it takes them to go from one house to another, the lack of infrastructure such as bathrooms and places to make notes and have meals, lack of safety when walking in dangerous areas, physical demand/exhaustion (carrying the weight of all visiting protocols of that day and constant exposure to climate change), adolescents who cancel the visit last minute and need to reschedule a new date for the HV, families who are defiant of nurse's guidance, lack of cooperation and contact with the basic care unit and other health services in the region to forward both health and social demands.

DISCUSSION

Many factors can influence the occurrence of pregnancy during adolescence and its good progression. Young pregnant women are a group at risk that require qualified prenatal and childbirth care, which may be neglected by late follow-up, financial barriers, stigma, disrespect, or a combination of these factors[11].

Millions of girls between the ages of 15 and 19 and under the age of 15 become pregnant and have children every year, but the majority live in low- and middle-income countries. Thus, many of these adolescents are vulnerable to the occurrence of unsafe abortion, resulting in deaths that could be avoided[11].

In this sense, the PJMC has been implemented with a focus on parenting in seeking to impact the results of the pregnancy and the development of the new generations. Based on international programs such as the NFP and MTB, the PJMC has a proposal of home visitation to reach its objectives.

Regarding prenatal follow-up of the adolescents by the PJMC, they were able to enter the program from the 8th to the 16th week of gestation. In this regard, the study points out that even though a large percentage of women access some prenatal care in their first pregnancy, prenatal follow-up often starts late, and these women are deprived of the best possible care. However, governments must ensure that adolescent mothers' accessed care to pregnancy is of high quality and tailored to meet their needs[12]; thus, the start time of follow-up by the PJMC seems adequate.

The current scheme proposed for the PJMC visits consists of an average of 58 to 63 visits to each adolescent made biweekly and distributed between prenatal, puerperal period and between 2 to 18 months of the child's life; however, due to several reasons this goal is not achieved in some cases. In an attempt to minimize such problems, the NFP develops a rigorous method of classifying household risks, as well as their strengths, which provide guidance to nurses and supervisors to adjust the frequency of visits with the objective of improving the effectiveness and efficiency of the program in carrying out the necessary number of visits forecasted for all families[13], and which can help the PJMC to re-evaluate the current scheme.

Regarding the "ideal" number of visits during prenatal care, the new guidelines of the World Health Organization (WHO) recommend a minimum of eight routine visits for first-time pregnant women, with initial contact in the first trimester, two contacts in the second trimester, and five contacts scheduled in the third trimester. And while this aspiration for additional care is welcome, an enormous investment would be required to achieve this increase in the number of prenatal visits to all women[14], therefore this may need to be prioritized for young women/adolescents as they are the most vulnerable group of pregnant women[11]. In this sense, the performance of HV by the PJMC exceeds the number of prenatal visits proposed by the WHO, considering that the monitored adolescents received an average of 11 HV during this period.

It is worth mentioning that the nurse's role in the prenatal consultation enables welcoming, bonding and interaction, the practice of health education and the professional commitment of the nurse to the pregnant woman and their family. The positive impact of their actions on prenatal consultation is evident, particularly regarding the recognition of the women's needs and the effort to integrate health actions[15].

The results of applying the NFP in American families showed an improvement in the sensitivity and responsiveness of the mothers to the child's needs, and improvement in children's mental development[4]. Longer follow-up studies of home visitation programs for prenatal and child care show a reduction in children's behavior problems, severe antisocial behavior and of substance abuse during the first 15 years of life. These studies also indicate a decrease in parental abuse and neglect[16].

Studies suggest that there is an association between parenting styles and drug use among adolescents, in which adolescents from negligent parents are more likely to use drugs, indicating that activities to reduce parental neglect should be included in drug prevention programs[17].

The results of women who participated in the MTB may also be cited, who described that their children had better behavior due to the program follow-up[18]; and studies have shown that the *Family Nursing Partnership* (FNP) implemented in England in 2007 based on the NFP has beneficial outcomes resulting from the implementation of this program in the United Kingdom[19-21].

Due to the several subjects discussed in each premise, we noticed that both adolescents and their children are benefiting, since the most covered topics during the 1-hour HV concern health care, followed by parenting, family, life project, social network and environmental health; themes which enable empowerment of the adolescent and her family, providing better results for themselves and for their children.

HV programs are increasingly being recognized as a service strategy to reduce poverty and mitigate its consequences, being an important part of early childhood care, making it possible to meet the needs of young and vulnerable families[2].

Investment in programs with this approach has proven effective in a number of domains, including family economic self-sufficiency, improving outcomes during labor and delivery, maternal health, child development, and positive parenting practices by promoting increased parental knowledge and skills[2].

In this context, the premises of the PJMC seek to serve young mothers in a holistic way, so that they develop parental skills in a positive way. In addition, to perform actions that other prenatal care programs cover such as nutritional, maternal interventions, fetal evaluation, preventive measures, interventions for common pregnancy symptoms and to encourage use of the health system to improve the quality of care[14], the PJMC uses evidence that loving and responsive care enhances positive outcomes across all dimensions of the child's life.

Thus, in order to achieve the program's goals, it is important to involve the family, which occurs in the implementation. Furthermore, prenatal care involves a personal and professional commitment by health workers, since it challenges them to overcome daily difficulties and seek (within feasible means) humane and comprehensive care for pregnant women. Therefore, recognition of the other is necessary to see a pregnant woman as someone marked by a life and family history, and having their culture as a guide for the care[22].

Finally, it is important to clarify that reaching children in the first years of life is a prerequisite for societal development[23]. Child health is a source of great concern and requires effective and appropriate parental interventions.

CONCLUSION

Implementation of the pilot project showed that the PJMC is an innovative intervention technology of great relevance in primary healthcare, with the ability to improve maternal and child care and to support the parenting development of adolescent mothers in order to make them more responsive and affective, thereby strengthening the mother-child bond.

We can point out HV as an aspect that has facilitated implementing this technology in nursing, which has proven to be an important tool for accomplishing the objectives of the program, for allowing more time for complex care, and focusing on the particularities of the family and its history. As challenges, we can point out the need for continuous investments in supervision and continuing education actions of the visiting nurses and their interlocution with the social and health services available in the region.

The lack of structure for carrying out the visits consisted of a limitation of the PJMC. In addition, there is a need to rethink the follow-up strategies of working adolescents that have children attending daycare centers in order to carry out the appropriate number of visits, ensuring the program's effectiveness.

The promising results of the PJMC indicate that this intervention technology can be expanded to primary care, so that it has greater impact on the health and quality of life of adolescents, their children and the families attended, thus promoting the development of future generations and society. In this sense, support from public agencies and investments in the training and continuing education of visiting nurses is required, which would be based on the premises of the PJMC so that these professionals will increasingly develop their skills regarding early childhood care through parenting.

RESUMO

Objetivo: Relatar a experiência de implementação do Programa de visita domiciliar Jovens Mães Cuidadoras. **Método:** O programa enfoca a relação mãe-criança como objeto do cuidado com vistas ao desenvolvimento da parentalidade e adota a teoria do apego, a teoria da autoeficácia e a teoria bioecológica como referenciais. A construção desse programa ocorreu a partir de materiais de programas de visitação internacionais, por meio da tradução do material, elaboração e validação do conteúdo teórico. **Resultados:** As visitas realizadas pelas enfermeiras tiveram duração média de 1 hora, nas quais foram abordados junto às adolescentes assuntos referentes aos cuidados com saúde, saúde ambiental, projeto de vida, parentalidade, família e rede social, além das demandas das adolescentes. Evidenciou-se que as enfermeiras encontraram dificuldades na implementação do programa. **Conclusão:** Ao adotar a visita domiciliar como ferramenta de cuidado com foco na parentalidade, a experiência de implementação do programa demonstrou ser uma tecnologia inovadora, com grande potencial e relevância para a promoção do cuidado à adolescente e ao desenvolvimento infantil.

DESCRITORES

Visita Domiciliar; Família; Adolescente; Desenvolvimento Infantil; Enfermagem Pediátrica; Enfermagem Familiar.

RESUMEN

Objetivo: Relatar la experiencia de implantación del Programa de visita domiciliaria Jóvenes Madres Cuidadoras. **Método:** El programa enfoca la relación madre-niño como objeto del cuidado con vistas al desarrollo de la parentalidad y adopta la teoría del apego, la teoría de la autoeficacia y la teoría bioecológica como marcos de referencia. La construcción de ese programa ocurrió a partir de materiales de programas de visitación internacionales, mediante la traducción del material, la elaboración y la validación del contenido teórico. **Resultados:** Las visitas realizadas por las enfermeras tuvieron duración media de una hora, en las que fueron abordados con las adolescentes temas referentes a los cuidados con la salud, salud ambiental, proyecto de vida, parentalidad, familia y red social, además de las demandas de las adolescentes. Se evidenció que las enfermeras encontraron dificultades en la implantación del programa. **Conclusión:** Al adoptar la visita domiciliaria como herramienta de cuidado con foco en la parentalidad, la experiencia de implantación del programa demostró ser una tecnología innovadora, con gran potencial y relevancia para la promoción del cuidado a la adolescente y al desarrollo infantil.

DESCRIPTORES

Visita Domiciliaria; Familia; Adolescente; Desarrollo Infantil; Enfermería Pediátrica; Enfermería de la Familia.

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