Cogitare Enfermagem

ORIGINAL ARTICLE

INTERFERENCES IN PRIMARY CARE FOR PUERPERAL WOMEN IN A BORDER REGION DURING THE COVID-19 PANDEMIC*

HIGHLIGHTS

1. Puerperal care in primary care with aggravated weaknesses by the pandemic.
2. The public health system in the border region is overloaded.
3. Failure to share information jeopardizes care continuity.

Rosenilda Duartes Fernandes Novakowiski[1]
Ana Paula Contiero[1]
Marli Terezinha Stein Backes[2]
Adriana Zilly[1]
Maria Aparecida Baggio[3]

ABSTRACT

Objective: To identify factors that have interfered with puerperal care in a border region during the COVID-19 pandemic. **Method:** qualitative research, using Grounded Theory as a methodological reference. It was developed in primary care in the triple border region of Brazil, Argentina, and Paraguay, with 30 participants, including puerperal women, health professionals, and managers. According to the Straussian perspective, data collection and analysis were collected between August 2021 and May 2022, following the stages of open, axial, and selective coding. **Results:** four subcategories were identified: "accessing health units", "understanding home visits and active search", "having insufficient information sharing in the care network" and "showing an overloaded health system". **Conclusion:** it was found that most of the factors that interfered with puerperal women's care already existed and were aggravated by the pandemic. It is recommended that measures be put in place to guarantee the sharing of information and timely counter-referrals.

KEYWORDS: Border Areas; Primary Health Care; COVID-19; Postpartum Period; Grounded Theory.

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[1]Universidade Estadual do Oeste do Paraná, Foz do Iguaçu, PR, Brasil.
[2]Universidade Federal de Santa Catarina, Florianópolis, SC, Brasil.
[3]Universidade Estadual do Oeste do Paraná, Cascavel, PR, Brasil.

INTRODUCTION

Puerperium is a period of biological, social, and emotional transformations in a woman's life, and primary health care (PHC) health professionals, through the bond established since prenatal care, can build a care plan for the period, according to individual needs, with a view to providing qualified care[1].

PHC is responsible for monitoring women during the puerperal period, developing health promotion, prevention, protection, and recovery actions, and is the first level of access for users of the Unified Health System (SUS)[2]. This monitoring is necessary because women can develop adverse events, such as bleeding, changes in blood pressure, and infection, among others, which can compromise their health and lead to unfavorable outcomes and even maternal death. It is, therefore, essential to guarantee continuity of care and reduce maternal morbidity and mortality by carrying out puerperal consultations[3].

In the COVID-19 pandemic, restrictive measures and social distancing were implemented in an attempt to reduce exposure to the SARS-CoV-2 virus. As a result, health services had to be reorganized to care for COVID-19[4] patients, which may have compromised care for women during the puerperal period. The triple border region, formed by Brazil, Paraguay, Argentina, and the whole world, had to adapt to the recommendations in force, with the temporary closure of the borders between the three countries. This has mainly harmed the health care of Brazilians living in other border countries, since Brazil's health system is of higher quality, according to users[5].

Given this scenario, it is noteworthy that border regions have different conditions from the rest in several respects. When it comes to health care, the municipality of Foz do Iguaçu, Brazil, has an increased demand for health care than the border municipalities of the other two countries[6]. It also absorbs demands from women in the pregnancy-puerperal cycle, with services for Brazilians living in Argentina and especially Paraguay, as well as foreigners who access Brazilian services with proof of address from relatives or friends living in Brazil[7].

Knowing that the adjustments made to the SUS during the pandemic have affected the provision of care to women in the puerperal period[8] and the particularities inherent to border regions, we ask: what factors have interfered with puerperal care in a border region during the COVID-19 pandemic? The aim of the study was to identify factors that interfere with puerperal care in a border region during the COVID-19 pandemic.

METHOD

A qualitative study using the Straussian Data-Based Theory[9] approach was carried out in the municipality of Foz do Iguaçu, Paraná, Brazil, in basic health units, the family health strategy, and the Maternal and Child Center (MCC).

The study had three sample groups and participants were selected for convenience. The first group was made up of 13 puerperal women; the second was made up of 13 health professionals who worked in the services in question, five of whom were doctors, six nurses, and two nursing assistants; and the third, finally, was made up of three-unit managers and one manager from the municipality's maternal and child area, totaling 30 participants.

Participants were contacted by text message using the WhatsApp® application, from a list provided by the PHC, or in person at the health service.

After presenting the purpose of the study and accepting, the participants indicated the date, time, and mode of interview (voice call via the WhatsApp® app or face-to-face),

according to their preference. And 26 interviews took place via voice call and four in person.

The interviews were conducted by a nurse with a master's degree, guided by the researcher in charge, with expertise in qualitative research and the method, using a semi-structured script. The interviews were audio-recorded and lasted an average of twenty-three minutes. They took place in a private place, guaranteeing privacy and confidentiality. Data collection and analysis took place simultaneously from August 2021 to May 2022.

The data was collected and analyzed systematically, using open, axial, and selective coding. During each stage of coding, the codes were grouped, regrouped, and sorted into categories and subcategories in an active process of going back and forth, necessary for understanding the data and identifying the phenomenon of the study, with the help of diagrams and memos. The repetition of data and the absence of relevant new information were criteria used not to include new participants[9].

The study is part of the multi-center project entitled "Coping with COVID-19 and Maternal and Child Care", approved by the Human Research Ethics Committee under opinion No. 4.837.617. It was carried out in accordance with National Health Council Resolutions No. 466/2012 and No. 510/2016 and Official Letter No. 2/2021/CONEP/SECNS/MS for research with a stage in a virtual environment.

To guarantee the anonymity of the participants, letters representing them were used, followed by a cardinal number, according to the order of the interview. P for puerperal women, PN for the professional nurse, PNA for professional nursing assistant, PD for the professional doctor, UM for the unit manager, and M for the manager, e.g., P1. . . P 13.

RESULTS

The puerperal women taking part in the study were aged between 25 and 43. As for color/race, seven identified themselves as white, five as brown, and one as black; as for family income, 11 reported incomes of between one and two minimum wages, one reported an income of less than one minimum wage, and one between three and four minimum wages. Of the thirteen participants, eight lived in Brazil and five in Paraguay.

Four subcategories were identified that correspond to the intervening factors in primary care for puerperal women in border regions during the COVID-19 pandemic.

Accessing health facilities

During the emergency period of the COVID-19 pandemic, health units offered three ways of accessing puerperal consultations: by appointment, on a specific day of the week without the need for an appointment, and by spontaneous demand.

Professionals and managers reported that the puerperal women received face-to-face care by spontaneous demand, mainly at the first puerperal appointment. Few units provided telecare during the initial period of the pandemic. Sometimes, when the puerperal woman didn't show up for her appointment, she would be contacted by telephone to schedule an appointment, and if this weren't possible, the professionals would try to gather information about the puerperium at the time of the contact.

It was only in-person [...] The first consultation was without an appointment; then they would schedule a day for us to return. (P13)

[...] only in person, because, like it or not, the nurse has to assess the healing, assess

everything. So, it was only in person. (UM2)

[...] We would call them, and they would tell us how they were doing. If there was a situation, we tried to resolve it and try to arrange a home visit to follow up, but we did this by phone. (M1)

Women came to the service mainly for the newborn's heel prick test in the first five days after birth, followed by the child's immunization and/or childcare, and not the puerperal consultation. When the puerperal women showed up for child care, they were picked up by the professionals for the puerperal consultation with the doctor and/or nurse, depending on the availability of the unit.

It can be by appointment, but it can also be spontaneous demand [...]. She usually goes there to do the heel prick test [...] they're more worried about the baby than themselves. So, we take advantage of the fact that they've had the heel prick test, the second test, and we fit them in for the puerperal appointment. [...]. (PN6)

[...] I went on the day that I was scared because blood had leaked out, so I went on the day and the doctor was there, so they put me straight through to the doctor and the other time I went was because it was the baby's day and I had my second heel prick test [...]. (P11)

It should be noted that the MCC has suspended its services for a few days. In this service, demand decreased in the first year of the pandemic, due to the closure of the bridge linking Paraguay to Brazil (from March to October 2020). As a result, it prevented Brazilian women living in Paraguay from accessing the health system and foreigners who cheated the system by presenting the addresses of relatives or friends living in Brazil as proof of residence.

It continued normally. We only stopped for 20 days. After that, of course, the demand decreased a lot due to the demand for the service. As a priority for Brazilian pregnant women living in Paraguay, there were a number of barriers. They came for prenatal care and were restricted [from access]. (PD1)

[...] We go after this puerperal woman to evaluate her and the baby. She's never lived here, nobody knows her, she's given someone her address, she's had prenatal care or not at all, sometimes she's had a consultation, she's had the baby, she's given her address and she's disappeared. Nobody can find her because she probably lives in one of the neighboring countries. (P6)

There was also a decrease in demand for puerperal consultations among Brazilians living in Brazil, especially at the beginning of the pandemic. This decrease was related to the fear of infection, the lack of immunization, the unknown aspects of the disease, and the repercussions of maternal and child.

[...] they were very afraid, both of themselves because of the situation and of the baby, they were afraid like that [...] I only realized that the search came much less [...]. [...] she [the *puerperal* woman] *hid a lot at home, and with good reason, the pandemic killed a lot.* (UM1)

[...] during the pandemic, clinical consultations were suspended, not prenatal consultations and not puerperium consultations, but then what happened, patients were also afraid to return, especially with their newborns, because of this COVID situation. (PN2)

[...] I was a bit scared [...]. But I went, and they always cared for themselves as much as possible. I tried to keep my distance, too. (P12)

The epidemiological condition of COVID-19 has also influenced access to puerperal consultations. The health units, their spaces, and their teams were (re)adapted to serve the population at different times. Some UBS has become a reference point for the care of users with respiratory symptoms. As a result, puerperal women were directed to access health

care in other units outside their catchment area. This interfered with puerperal follow-up due to the temporary loss of the link with the unit of origin or, in the worst case, not being attended to at all.

[...] when there was this moment [...] we had respiratory care and kept some other things [...] we kept our care [...] this office and the one in front were offices that were COVID care [...] in a second moment, we ended up taking these pregnant women, that was a very difficult moment, to tell the truth [...]. (PD5)

Understanding home visits and active search

During the pandemic, home visits did not take place and were justified on the grounds of social isolation, although they were no longer a common practice in the period before the pandemic due to the coverage area and an insufficient number of health professionals, particularly community health workers (CHWs).

[...] Before the pandemic, we had postpartum consultations. When I heard that the woman had had a baby, we went to visit the house. With the pandemic, this has diminished [...] we end up not going to patients' homes very often, especially at the beginning of the pandemic, when there was nothing. [...] It's not just the postpartum, the baby, and the husband; sometimes there are her parents, his parents [...]. Then we ended up not going; we didn't do it. (PN3)

[...] it's an area of kilometers, about 40 km, maybe even more, from one end to the other. It's impossible for us to make visits, and we have CHAs; I think there are eight CHAs here [...] we end up taking on other areas as well [...]. (PD5)

The active search for puerperal women continued to be carried out by some professionals, either in person or by telephone. However, not everyone was doing it, even before the pandemic.

The active search also continued for prenatal and puerperium absentees, even though we didn't have enough CHWs to cover the whole area [...]. (PN2)

[...] We can send messages but can't ask questions. We didn't do that, but they were free to pick it up and send a message. [...] We don't do an active search. (PN1)

[...] We only have two community health agents. We're out of date [...]. For total coverage, we would need 19 agents. So, it's difficult for us [the CHWs] to go *after all the puerperal [...].* (UM2)

Only one puerperal woman said she had received a home visit from the CHW two months after giving birth, and the reason for the visit was not related to puerperal care, but to the children's immunizations.

She asked if everything was all right with the vaccine and looked at the children's booklets, but not me in general (P4).

It was found that the boundaries between the borders interfered with the active search for absentees, either through home visits or telephone contact. Brazilians living in neighboring countries, and even foreigners, often go for prenatal care in Brazil (first at the MCC) and, after giving birth, do not return for puerperal care. Home visits or active searches are not carried out for these women because they live in another country and there are no international agreements for these actions.

[...] we have cases here of mothers [...] when we went to do the active search, they were already in Paraguay [...]. (UM1)

[...] Now and then, we receive a request for an active search, but because the children who were born at high risk, had some condition that was classified as high risk, then we go after this puerperal woman to evaluate her and the baby and she never lived here, nobody knows her, she gave us someone's address. [...] (PN6)

Insufficient information sharing in the care network

It was found that there is no integration or sharing of labor and birth data between the different levels of health care for the follow-up of women after childbirth. Puerperal women return to PHC without recording any information about the care they received in secondary and tertiary care. The professionals obtain this information through the pregnant woman's own report, which may be incomplete or inconsistent (regarding the birth, complications, and/or treatments). This can interfere with continuity of care.

[...] the hospital never sends a counter-referral, even if we refer a pregnant woman, it's an individual situation for the professional [...], 99% of what is referred doesn't come back with a counter-referral. The patient returns but without a counter-referral. So, we know, we have an idea of what happens with what the patient reports [...]. (PN2)

When I was discharged, they told me nothing about it, that I had to go for a consultation. Regarding the stitches I had, the doctor who released me said that the stitches would fall out on their own [episiotomy] *and then they gave me some medicine to apply to the bandage*. (P2)

In addition, PHC professionals do not receive live birth certificates (DNV), a condition that would allow them to know which women have already given birth and to identify those who have not in order to provide timely care.

[...] In the other municipality where I worked, we received people at all risks, high risk, normal risk, and intermediate risk. The only child we have received [in Foz do Iguaçu] *is a high-risk child [...].* (PN5)

The guidance that women receive during the pregnancy-puerperium cycle in the health care network about puerperal follow-up is insufficient or mistaken, such as seeking PHC within 15 days of giving birth.

[...] Perhaps there is a lack of guidance during prenatal care about the importance of the puerperal appointment so that they can take an interest and stay with us. (M1)

[...] They just told me to be careful at home, not to make any physical effort, and then we'd go with the baby to the maternity center. (P11)

The doctor gave me some medication to take and told me to go and make an appointment to see a nurse at the clinic 15 days later. Then I went after seven days, then the nurse asked me to go after 15, to remove the stitches, which the doctor told me to do more to remove the stitches. (P4)

Evidence of an overloaded health system

Due to the municipality's geographical location, residents of neighboring countries (both Brazilians and foreigners), especially Paraguay, cross the border to receive health care in Brazil. This overloads the health system because users living in neighboring countries are also cared for in addition to routine care for the population in the area covered by the units. This overload of care interferes with carrying out preventive actions, including those related to the puerperium.

[...] We can't even really contemplate who the resident is, who is here, the resident. It's not those foreigners don't have the right, they do as long as they do the Brazilian documentation as foreigners [...]. (PN2)

[...] the demand interferes a lot, whether we like it or not, Brazil is a nursery to help other countries, we see that there are many people who sometimes get documentation or have a relative who lives here [...]. (PD2)

[...] We're very rushed, we're not managing to do the prevention we used to be able to do. Health promotion is kind of automatic because there's a lot of demand, and during the pandemic, a lot of professionals were laid off. Vaccination started, so we adapted to the situation [...]. (PN4)

In addition to the border condition, the professionals pointed out that the areas covered by the health services are very large in population and territory, with limited human resources, interfering with PHC health actions, particularly those focused on the puerperium. Furthermore, there are no planned actions for the care of Brazilian puerperal women living in Paraguay, or foreign women who access Brazilian health services. In addition, the demand for care was very high during the emergency period of the COVID-19 pandemic.

DISCUSSION

In the puerperal period, women go to the health units in the first few days after being discharged from the hospital, not to see them but to see the child, usually for the heel prick test. This type of access was already described prior to the pandemic[10] and has continued during its course.

The COVID-19 pandemic has impacted health services worldwide, forcing them to readjust their flows to meet existing demand caused by the pandemic. In this direction, some measures have been encouraged, such as reducing the number of face-to-face prenatal and puerperal consultations, increasing the use of telecare, and speeding up childbirth and early discharge[11].

In Brazil, puerperal and pregnant women have been included in the risk group for COVID-19, due to the vulnerability of women during this period and the increased risk of developing serious complications, and it is recommended that care be provided to this group on an ongoing basis[12].

In this study, only two units offered tele-service, but for a short period of time and with a small number of professionals. A study carried out in the United States found that telemedicine was widely used during the period of greatest restriction; however, most of the participants described the virtual care as insufficient; they said they believed they did not receive necessary and adequate care for themselves and their NB[13] and also complained of insufficient resolution of health problems, technical difficulties and problems in establishing relationships with care providers[14].

Teleservice can be used as a complement to face-to-face service. This type of care makes it possible to alternate face-to-face and remote consultations, offer guidance on caring for women and NBs, and monitor risk situations in order to prevent complications[15].

The triple border region in Foz do Iguaçu has a large flow of people crossing the borders for trade, tourism, work, and health. One of the measures to try to contain the circulation of the virus was the closure of the borders in this region, including the closure of the International Friendship Bridge, which connects Brazil and Paraguay, between April and October 2020. The bridge's closure has affected people's lives, including health. The mainly socially vulnerable border population seeks health services in Brazil due to the perception

that the services offered in this country are better than in their country of residence[5,16].

Cross-border pregnant and postpartum women not only suffer from vulnerabilities related to the pregnancy-puerperium cycle but also live far from the health services where they are monitored. A study carried out in the border region of Paraná states that geographical location is one of the barriers to access; the fact of living in one municipality and having to travel to another to receive health care or having to travel long distances to access the service can affect the health of these users[17]. With the temporary closure of the bridge during the COVID-19 pandemic, access to health care has been difficult.

In addition to these problems, the data shows that the puerperal women were afraid of infecting themselves or their newborns. However, most of them showed up at the PHC units for their puerperal appointments, even if they were late. In the UK, a study indicated that the majority of women in the pregnancy-puerperal cycle reported that the pandemic had interfered with health care, with appointments being canceled or rescheduled and care being provided remotely[18].

Although PHC is responsible for monitoring women's health after childbirth, with home visits by the nursing team up to the fifth day after childbirth, incentives for breastfeeding, sexual and reproductive planning, and puerperal consultations - the first between seven and ten days postpartum and the second up to 30 days, there are weaknesses in the implementation of these actions[19].

A study carried out in the state of Paraná corroborates the findings of this research on home visits when it describes that not all PHC units carry out home visits and that the initiative for timely puerperal follow-up lies with the puerperal woman. The same study identified shortcomings in counter-referrals, a lack of information to puerperal women about the importance of follow-up during the puerperal period, care focused on the child, and not carrying out physical examinations on all patients, with a greater emphasis on prescribing medication and contraceptives[20].

In addition, the border region has specific characteristics that differ from other regions. An active search is carried out, but not in full, for mothers who don't show up at the health unit in the first week. However, it is impossible to conduct an active search for those living in neighboring countries[7].

Regarding the sharing of information in the care network and guidance on the need for puerperal consultations, a study carried out in Bahia corroborates the findings of this research, describing that the lack of planning and systematization directly interferes with the care of puerperal women and their newborns; as has been explained, there is no effective communication between PHC and the hospital network[21].

In this study, the PHC scenario had pre-existing problems and weaknesses, aggravated by the COVID-19 pandemic. The dismissal of professionals from the risk group or those infected by COVID-19 and the increased demand for care has caused an overload in health systems, with the need to reorganize units for continuity of care. Measures had to be implemented, such as suspending group activities, separating physical space between symptomatic and non-symptomatic patients, and suspending elective consultations, except for risk groups, including pregnant women and puerperal women[22].

It should be noted that in the border region, the overload of health systems is also related to the care of cross-border travelers. This is due to the increase in demand from Brazilians and foreigners living in neighboring countries, which leads to a reduction in structural, financial, and human resources in health services; it is considered that this population is not counted for the SUS financial transfer, since the transfer of funding is according to the population residing in the municipality[23].

The study was limited to interviewing puerperal women, health professionals, and primary care managers in a border municipality. It is suggested that other studies include

other levels of care and border municipalities to confirm or include new data on the subject.

FINAL CONSIDERATIONS

Among the factors that interfered with the health care of puerperal women in the triple border region of Foz do Iguaçu during the pandemic period, the following stood out: predominantly face-to-face care, lack of home visits, fragility in active search, a deficit in sharing information between the levels of care and overload of the health system due to the particularities of the border region, added to the demands caused by the pandemic.

It is recommended that remote care be combined with face-to-face care at the health unit, in the event of epidemiological conditions that prevent it from being carried out in person. Measures to share information and counter-refer between the different levels of care are necessary for the care of puerperal women.

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Corresponding author:
Maria Aparecida Baggio
Universidade Estadual do Oeste do Paraná
R. Universitária, 1619, Jardim Universitário, Cascavel - PR – Brasil - CEP: 85819-110
E-mail: mariabaggio@yahoo.com.br

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Novakowiski RDF, Baggio MA.** Drafting the work or revising it critically for important intellectual content - **Novakowiski RDF, Contiero AP, Backes MTS, Zilly A, Baggio MA.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Novakowiski RDF, Contiero AP, Backes MTS, Zilly A, Baggio MA**. All authors approved the final version of the text.

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