Original Article

Women's care during home visits for the "First Comprehensive Healthcare Week"

Cuidados prestados à mulher na visita domiciliar da "Primeira Semana de Saúde Integral"

La atención prestada a la mujer en la visita domiciliar de la "Primera Semana de Salud Integral"

Laura Lucinda Bezerra Silva[a,b]
Katia Virginia Oliveira Feliciano[b]
Lorena Novaes Ferraz Pacheco Oliveira[a]
Evelyne Nascimento Pedrosa[b]
Maria Suely Medeiros Corrêa[c]
Ariani Impieri Souza[a,b]

How to cite this article:
Silva LLB, Feliciano KVO, Oliveira LNFP, Pedrosa EN, Corrêa MSM, Souza AI. Women's care during home visits for the "First Comprehensive Healthcare Week". Rev Gaúcha Enferm. 2016 Sep;37(3):e59248. doi: http://dx.doi.org/10.1590/1983-1447.2016.03.59248.

doi: http://dx.doi.org/10.1590/1983-1447.2016.03.59248

ABSTRACT

Objective: To evaluate women's care during home visits for the "First Comprehensive Care Week".

Method: A cross-sectional study was carried out in a specialized service in Recife, Pernambuco, Brazil. A total of 190 women who had recently given birth enrolled at the Family Health Strategy answered the questionnaire between September and December 2013 to verify the association between home visits and the investigated variables. This association was verified using the chi-square test with a confidence level of 95%.

Results: Most of the women were 29 years old or under (68.5%), with high gestational risk (59.5%), and primiparous (46.9%). On the first week after hospital discharge, 42.1% received a home visit. An association was detected between local pre-natal care and a home visit on the first week ($p = 0.049$). The participation of the nurses during the visits was associated with better performance for breast and abdomen examinations ($p = 0.000$) and investigations on emotional conditions ($p = 0.029$).

Conclusions: These findings stress the need to establish a routine home visit plan to solve the issues of women with high-risk pregnancies after labour.

Keywords: Postpartum period. Home visit. Family health strategy. Woman's health. Health evaluation.

RESUMO

Objetivo: Avaliar o cuidado prestado à mulher na visita domiciliar da "Primeira Semana de Saúde Integral".

Método: Estudo transversal realizado em serviço especializado do Recife, Pernambuco. Entre setembro e dezembro de 2013, 190 puérperas cadastradas na Estratégia Saúde da Família responderam a um questionário para verificar a existência de associação entre a visita domiciliar e as variáveis investigadas, utilizando o teste Qui-quadrado, com nível de confiança de 95%.

Resultados: Predominou idade de até 29 anos (68,5%) e risco gestacional alto (59,5%), sendo 46,9% primíparas. Na primeira semana pós-alta, 42,1% receberam visita. Constatou-se associação entre atenção pré-natal em nível local e visita na primeira semana (p=0,049). A participação do enfermeiro na visita estava associada à maior realização de exame de mama (p=0,000), abdômen (p=0,000) e investigação de condições emocionais (p=0,029).

Conclusões: Evidencia-se a necessidade de instituir um planejamento rotineiro para efetuar a visita domiciliar programática, priorizando as puérperas de risco.

Palavras-chave: Período pós-parto. Visita domiciliar. Estratégia Saúde da Família. Saúde da mulher. Avaliação em saúde.

RESUMEN

Objetivo: Evaluar la atención prestada a la mujer en la visita domiciliaria de la "Primera Semana de Salud Integral".

Método: Estudio transversal, realizado en servicio de nivel terciario, en Recife, Pernambuco. Entre septiembre y diciembre de 2013, 190 madres inscritas en la Estrategia Salud de la Familia respondieron a un cuestionario para verificar la existencia de asociación entre las visitas domiciliarias y las variables investigadas. Se utilizó el Chi-cuadrado, con nivel de confianza del 95%.

Resultados: Predominó edad hasta los 29 años (68,5%) riesgo gestacional alto (59,5%), de los cuales el 46,9% primíparas. La primera semana posalta, el 42,1% recibió VD. Se constató asociación entre atención prenatal en el nivel local y visita en la primera semana (p=0,049). La participación del enfermero en visita estaba asociada a mayor realización de examen de mama (p=0,000), abdomen (p=0,000) e investigación de condiciones emocionales (p=0,029).

Conclusiones: Necesidad evidenciada de instituir planificación de rutina para efectuar visita domiciliaria programática, priorizando puérperas de riesgo.

Palabras clave: Periodo posparto. Visita domiciliaria. Estrategia de salud familiar. Salud de la mujer. Evaluación en salud.

[a] Faculdade Pernambucana de Saúde (FPS), Recife, Pernambuco, Brasil.

[b] Instituto de Medicina Integral Prof. Fernando Figueira (IMIP), Recife, Pernambuco, Brasil.

[c] Universidade de Pernambuco (UPE), Faculdade de Enfermagem Nossa Senhora das Graças. Recife, Pernambuco, Brasil.

INTRODUCTION

Maternal morbidity and mortality is a global challenge, and most cases affect women in the immediate puerperium (day 1 to 10). Despite a drop in these rates in the last 20 years, the global maternal mortality ratio (MMR) was 210 deaths per 100,000 live births, in 2013, and 14 times higher in developing regions[1]. Mortality, however, is only a visible fraction of the problem of maternal morbidity[2-3].

In Brazil, after the decrease of MMR mainly due to a drop in deaths with direct obstetric causes, in 2013, the ratio was 69 deaths per 100,000 live births[1]. As in the case of Latin America and the Caribbean, avoidable deaths caused by hypertensive and haemorrhagic diseases still exist, and there is a significant number of deaths with undefined causes[4]. This profile reinforces the importance of healthcare in the first few days postpartum.

Although the results of a systematic review on the effects of healthcare on the immediate puerperium have been inconclusive[5], a study of almost two decades found relatively lower death rates between mothers who received home visits from nurses during this period[6]. Furthermore, research on the occurrence of maternal morbidity indicates the need to create programmatic actions to ensure the early detection of health issues among women who have recently given birth[2-3].

In a review with meta-synthesis, women in Brazil, South Africa, Switzerland, and England mentioned the importance of home care provided by the health team within the first week postpartum[7]. In the transition from hospital to home, especially among primiparous women, it is important to ensure confidence regarding self-care and the role of being a mother. The reported experiences, however, revealed a lack of home care or dissatisfaction with the care that is provided[7].

The puerperium is one of the basic practice areas of the Family Health Strategy (FHS), the preferred model of primary healthcare (PHC) in Brazil[8]. The National Pact for the Reduction of Maternal and Neonatal Mortality was established as a strategic action for the initiative First Comprehensive Care Week ("PSSI") of the Ministry of Health (MS) to expand coverage and qualify care for women who had recently given birth and their newborns (NB), thus strengthening care in the Primary Care Service (PCS)[9].

The PSSI recommends home visits within the first seven days after discharge from the maternity hospital, and within the first three days when the newborn is classified as high risk. In women's care, home visits are used to know the conditions of childbirth, assess the health status of the mothers, mother-child interaction and the return of the mother's organism to pre-pregnancy conditions, verify emotional and social conditions, identify risk situations and complications to adopt the correct conduct, support breastfeeding, provide advice on self-care, and schedule a puerperium appointment before the 42nd day after delivery. Consultations at the healthcare service from seven to ten days postpartum should be encouraged in the home visit[9].

At the FHS, home visits are the main role of community health agents, although this responsibility is shared by all team members[8]. The actions established in the PSSI involve, above all, the nurse and the community health agents, and medical assessments are requested when any alterations are detected[9].

Therefore, this study sought to answer the following research question: Did the women who underwent a postpartum review at the unit of reference receive the care actions established by the MS for home visits at the PSSI? The objective of this study was to evaluate the care provided to women during the home visits of the "First Comprehensive Care Week".

METHOD

This is an evaluative study, in which the value judgement regarding the intervention is the result of the application of criteria and standards that govern the provision of foreseen actions[10]. This study also has a cross-sectional design. It was conducted from September to December 2013, in Recife, Pernambuco, Brazil with a sample of 190 women (median postpartum of 19 days, interquartile range of 12 to 23 days). These women underwent a postpartum review at the Postnatal Outpatient Unit at a tertiary level general hospital of the Unified Health System ("SUS"). This hospital is a benchmark in northeastern Brazil for the care of women and children. To calculate the sample size, 40% of the home visits were estimated during the first week after discharge with a significance level 95% and 7% error.

In the absence of information about frequency of these home visits, a value closer to 50% was chosen, which would result in a larger sample. Considerations regarding the time available for research, the objective of contributing to the planning of puerperium actions and the possibility of appropriately supervising and controlling the quality of the process, provided that a margin of error of 7% (for the result to be between 33% and 47%) would allow for acceptable accuracy.

Convenience sampling was conducted by two of the authors who were duly trained to identify and recruit eligible women, apply the questionnaire, and ensure correct

completion of the instrument. During each collection shift, based on the list of women who received care at the unit, a nominal listing was created of those women who complied with the inclusion criteria of the study, namely women residing in the state of Pernambuco and registered at the Family Health Unit (FHU). None of the women were rejected or excluded. After being informed of the research and signing an informed consent statement, the women answered the questionnaire containing information of their social and demographic profile, obstetrical and neonatal characteristics, and women's care.

Data were analysed using the software Epi Info 3.5.4. The following associations were detected: (1) home visits and high-risk pregnancy, number of the pregnancies and prenatal location; (2) high-risk pregnancy and activities for women during home visits; (3) workers who visited the mothers with the provided activities and with level of satisfaction. Significant differences were assessed using the chi-squared test and the Exact mid-P method, when necessary, with a confidence level of 95%. The term "trends" was used for results with statistical significance between 0.05 and 0.10.

The project was approved by the research ethics committee of the Instituto de Medicina Integral Prof. Fernando Figueira, according to opinion n° 3714 of 11/09/2013.

RESULTS

Most of the women lived in the metropolitan region (45.3%) and city of Recife (35.3%), Brazil. The age distribution was between 12 and 45 years, with a median age of 25 years (interquartile range of 21 to 31 years). Adolescents (12 to 19 years) accounted for 16.8% of the recent mothers. The majority of women lived with a companion (75.3%), and 46.9% lived in consensual unions. Median schooling was 11 years (interquartile range of 8 to 11 years), while 60.0% had studied for 9-11 years and 5.8% between 12-

Table 1 – Characteristics related to prenatal care and childbirth of women assisted at a benchmark service in Recife, Pernambuco, Brazil, 2013

Variables	N	%
Location of prenatal care (n = 190)		
Family health unit	73	**38.4**
High complexity service	60	31.7
Family health unit + High complexity unit	39	**20.5**
Medium complexity service	12	6.3
Family health unit + Medium complexity unit	06	**3.1**
Type of delivery (n = 190)		
Vaginal without episiotomy	22	11.6
Vaginal with episiotomy	64	33.7
C-section	104	**54.7**
High-risk pregnancy (n = 190)		
Yes	113	**59.5**
No	77	40.5
Reason for high-risk pregnancy (n = 113)		
Arterial hypertension	58	**51.3**
Arterial hypertension + Diabetes mellitus	13	**11.5**
Diabetes mellitus	06	**5.3**
Other diseases	26	23.0
Diseases of the fetus	05	4.4
Pre-adolescent mother	02	1.8
No information	03	2.7

Source: Research data, 2013.

16 years. Around 53.0% of the women performed unpaid domestic tasks. Of those who were employed, 56.8% performed manual work (32.9% semi-specialised and 23.9% unqualified). Around 46.9% were first-time mothers.

Approximately 62.0% of the women received prenatal care at the FHU (38% of which simultaneously received care at another service). C-section was the most common form of delivery (67.3% in high-risk pregnancy), followed by vaginal delivery with episiotomy. A total of 59.5% had had high-risk pregnancies, of which 62.8% suffered from isolated hypertension or hypertension associated with diabetes mellitus (Table 1).

The first week after discharge, 42.1% of the women received home visits (5% of which were not at home). The community health agents accounted for 85% of the visits, of which 38.7% were made with a top-level professional, almost always the nurse. Of the 15% home visits of top-level professionals, 83.3% were nurses (Table 2).

Around 71.2% of the women who received home visits the first week after discharge completed their prenatal follow-up at the FHU. Of these women, 66.7% were assisted only by the local team. A statistical association was found between prenatal care at the FHU and home visits the first week after discharge ($p = 0.049$). There was no association between number of pregnancies and home visits the first week after discharge ($p = 0.876$). Of the women who received a home visit, 47.5% were primiparous mothers.

The most frequent activities for the women were: enquire about breastfeeding (77.6%), recommend the use of ferrous sulphate (75.0%), ask about diet (64.5%), and provide breastfeeding guidelines (64.5%). The least common activities were: evaluate volume (15.8%) and odour of genital bleeding (15.8%) and examination of the genital region (27.6%). The participation of a professional (physician and/or nurse) in the home visits, alone or accompanied, resulted in a significantly higher development of eight of the 22 recommended activities, or a trend for a higher frequency of four of these activities. In these circumstances, the performed activities were: ask about breastfeeding and diet, and recommend the use of ferrous sulphate (Table 3).

Around 40.9% of the women with high-risk pregnancies received home visits. There was no association between gestational risk and home visit ($p = 0.987$). Similarly, no association was found between gestational risk and performance of the activities established for women's care during the first week after discharge. A trend was observed for greater investigation of complaints ($p = 0.093$) and questions about diet ($p = 0.076$) among women with low gestational risk (Table 3). No association was identified between type of delivery and home visits ($p = 0.219$).

A total of 56.6% of recent mothers were satisfied with the women's care guidelines and 69.8% were satisfied with the care provided during the home visits in the first week after discharge (Table 4). The participation of physicians and/or nurses in the home visits were not associated with the opinions regarding women's care guidelines ($p = 0.121$) and the provided service ($p = 0.232$).

Table 2 – Home visits and team members who visited the recent mothers assisted at the benchmark service in Recife, Pernambuco, Brazil, 2013

Variables	N	%
Team member visited the mothers (n = 190)		
The visit was completed	76	**40.0**
Woman was not at home	04	**2.1**
No visit	110	57.9
Team member who visited the mother at home (n = 80)		
Community health agent	37	**46.2**
Community health agent + nurse	28	**35.1**
Nurse	10	**12.5**
Community health agent + nurse + physician	02	**2.5**
Community health agent + physician	01	1.2
Nurse + physician	01	1.2
Physician	01	1.2

Source: Research data, 2013.

Table 3 – Women's healthcare during home visits of the family health strategy to recent mothers in a benchmark service of Recife, according to the person in charge of the visit and gestational risk, Recife, Pernambuco, Brazil, 2013

Variables	Visitor					Gestational risk				
	Community health agent (n = 35)		Professional with/ without community health agent (n = 41)		*p*	High (n = 45)		Usual (n = 41)		*p*
	N	%	N	%		N	%	n	%	
Requested the discharge summary	21	60.0	26	63.4	0.766	30	66.7	17	54.8	**0.311**
Eye examination	07	20.0	17	41.5	**0.049**	16	35.6	08	25.8	**0.385**
Breast examination	07	20.0	26	63.4	**0.000**	21	46.7	12	38.7	**0.504**
Abdominal examination	06	17.1	29	70.7	**0.000**	20	44.4	15	48.4	**0.741**
Examination of the genital region	02	5.7	19	46.3	**0.000**	13	28.9	08	25.8	**0.780**
Examined stitches	05	14.3	29	70.7	**0.000**	22	48.9	12	38.7	**0.394**
Examined lower limbs	09	25.7	17	41.5	0.160	17	37.8	09	29.0	**0.445**
Examined amount of bleeding	**03**	**8.6**	**09**	**21.9**	0.124	06	13.3	06	19.4	**0.498**
Examined the odour of bleeding	**03**	**8.6**	**09**	**21.9**	0.124	06	13.3	06	19.4	**0.498**
Asked if there were any complaints	14	40.0	26	63.4	**0.046**	20	44.4	20	64.5	**0.093**
Asked about emotional conditions	**08**	**22.8**	**20**	**48.8**	**0.029**	14	31.1	14	45.2	**0.226**
Asked about breastfeeding	**24**	**68.6**	**35**	**85.4**	0.091	33	73.3	26	83.9	**0.297**
Asked about diet	18	51.4	31	75.6	**0.032**	26	57.8	23	74.2	**0.076**
Explained how to care for stitches	17	48.6	28	68.3	0.089	27	60.0	18	58.1	**0.868**
Guidelines regarding personal hygiene	15	42.8	24	58.5	0.184	22	48.9	17	54.8	**0.620**
Guidelines for breastfeeding	**20**	**57.1**	**29**	**70.7**	0.230	27	60.0	22	71.0	**0.341**
Guidelines for diet	17	48.6	26	63.4	0.205	23	51.1	20	64.5	**0.259**
Recommended the use of ferrous sulfate	**23**	**65.7**	**34**	**82.9**	0.095	32	71.1	25	80.6	**0.364**
Guidelines on reinitiating sex	14	40.0	18	43.9	0.739	19	42.2	13	41.9	**0.982**
Guidelines regarding emotional state	09	25.7	19	46.3	0.069	18	40.0	10	32.3	**0.506**
Guidelines regarding family planning	19	54.3	23	56.1	0.877	27	60.0	15	48.4	**0.330**
Inquired about puerperal appointment	**22**	**62.8**	**26**	**63.4**	0.960	28	62.2	20	64.5	**0.846**

Source: Research data, 2013.

Table 4 – Level of satisfaction of recent mothers regarding the home visits of members of the family health strategy from a benchmark service of Recife, Pernambuco, Brazil, 2013

Level of satisfaction (n = 76)	Women's health guidelines		Medical assistance	
	n	%	n	%
Very satisfactory	**11**	**14.5**	**17**	**22.4**
Satisfactory	**32**	**42.1**	**36**	**47.4**
Fairly satisfactory	17	22.4	13	17.1
Unsatisfactory	09	11.8	07	9.2
Very unsatisfactory	07	9.2	03	3.9

Source: Research data, 2013.

The opinions of the women regarding the guidelines were not significantly affected by the location of prenatal care (p = 0.309), by the fact that the women was primiparous (p = 0.488) or by having a high-risk pregnancy (p = 0.252). Similarly, considerations regarding the care received during the home visits showed no statistical association with the location of prenatal care (p = 0.486), with being a primiparous mother (p = 0.349) or with having a high-risk pregnancy (p = 0.428).

DISCUSSION

In this study, the frequency of home visits the first week after discharge was low (42.1%) although the PSSI recommends attributing a strategic nature to these programme actions[9]. When compared to a multicentre study, the proportion of home visits the first week after discharge in this study was lower than the proportion found in Bangladesh (57%) and Nepal (50%), and notably higher than the proportion found in Malawi (11%) in relation to home visits three days postpartum[11]. Unlike the pact, the information system for the prenatal and birth humanisation programme ("SISPRENATAL") does not include the percentage of women who received home visits in the puerperium in its process indicators[9].

The MS recommends that the teams should routinely schedule home visits to give priority to higher risk situations[8-9]. The overlap of low home visit frequency the first week after discharge and lack of use of risk criteria for visits is worrisome, especially since, among the studied group, 59.5% of women had high-risk pregnancies. Not even the recent mothers with hypertension and diabetes during pregnancy were given priority despite the exposure of these mothers to a high risk of postpartum glucose intolerance, cardiovascular diseases, and future diabetes mellitus in comparison with the mothers who had healthy pregnancies[12].

The percentage of adolescents in the sample demonstrates the importance of organising health services to assist and monitor this population group in the puerperium. Aside from the issues of maturity and responsibility regarding the challenges of motherhood, weight gain among pregnant adolescents tends to be greater than weight gain among adult women. Preventing postpartum weight gain has immediate benefits for women's health and can protect women from early-onset obesity, which contributes to the intergenerational transmission of disease[13].

The rate of C-sections (54.7%) performed at the units for high-risk pregnancies is another important aspect of this study. Women with clinical and obstetric complications accounted for approximately two thirds of the C-section deliveries. The World Health Organization (WHO) asserts that in the absence of medical reasons, C-sections have no benefits and, as with all surgeries, pose immediate and long-term risks. The WHO also suggests studies to assess the association between C-section rates and perinatal and maternal morbidity, and the psychosocial implications associated with this type of delivery[14]. A qualitative study conducted in Recife, Pernambuco, found that the vulnerability women feel after undergoing a C-section forces them to enquire about priority care for their condition[15].

In Brazil, studies show that the planning of home visits was non-existent or asymptomatic. In general, the home visits were only provided by community health agents or top-level professionals separately, and never by at least two members of the team. The team was only present on specific occasions when the need for other professionals during the visits was previously identified. The home visits of nurses often depended on the evaluation of the community health agents, who used their own criteria to define priorities since there is no established risk classification[16-17]. In some cases, the community health teams requested the presence of a physician at the home[17], while in others it was the nurses who made the request[16]. Fragile interpersonal relationships and difficulties in dealing with the fragmentation of work led to little interaction between nurses and community health agents[16].

According to the community health agents, some obstacles prevent them from dedicating more time to home visits, such as overlapping responsibilities, the need to visit the same family more than once a month, and the singularities of each region and population. A high number of assignments and limited time led the nurses to prefer service activities, such as nursing consultations, to home visits. The nurses also mentioned that fear of walking into the community area[16] was a hindrance to home visits. The physicians, however, criticised the lack of preparation of the community health agents to identify needs and schedule home visits[17].

Home visits should enable the development of educational activities and the early identification of risks and complications within the family setting. It is a privileged moment to provide the problem-solving actions that observe the healthcare needs and value the choices of patients[16-17]. Greater approximation with the reality of these patients during postpartum visits can strengthen worker/team/user and family ties, and increase mother and child health protection. For the health workers to insert themselves into the family setting and understand its dynamics regarding health issues, they must be able to listen attentively and have contextual knowledge. Nursing education

must teach nurses the skills to mediate their technical knowledge and the practical knowledge of laypersons

In the obtained results, the community health agents were mainly responsible for the home visits, while the nurses were practically the only healthcare professionals who took part in the visits. The participation of nurses has improved the quality of care because it significantly increases the frequency of related activities (physical examination, enquiring about complaints and emotional state). Even with the presence of a healthcare professionals (physician or nurse), there was restricted access to important care activities recommended for the immediate puerperium. In many cases, biological changes of the puerperium were not observed, such as involution of the uterus and bleeding, elimination of the lochia, distension of the abdominal musculature, and conditions of the perineum and the breasts. Some of the most frequent activities performed by the team members during the home visits were enquiries and guidelines regarding breastfeeding

Only 52.6% of the women were asked about complaints regardless of the level of risk of their pregnancies. In Marrakesh, a study found that 44% of women who had recently given birth had postpartum complaints. Mental distress (anxiety, crying, nervousness) was the most common complaint, followed by vaginal discharge and breastfeeding problems, infected episiotomy, and burning sensation when urinating, among others[2]. In Brazil, there is evidence of the dissatisfaction of women with the lack of interest in their complaints during the puerperium home visits[15, 18]. A better understanding of postpartum complaints is critical to improve the quality of women's healthcare.

Despite the importance of detecting emotional changes during home visits in the immediate puerperium, the emotional state of the women was rarely investigated (36.8%). During this period, 50% to 70% of recent mothers suffer from baby blues, a mild depressive state that generally appears on the third day after delivery and lasts for approximately two seems[9]. Concerns, anxiety, and stress triggered by the difficulties and insecurities of self-care and caring for the newborn, which were relatively neglected by the healthcare team, has led women to request specialised assistance for first-time mothers[7,15].

Immediate puerperal anaemia is more common than previously thought, and can manifest as pallor, fatigue, dizziness, loss of appetite, and swelling. If untreated, it can seriously affect women's physical and emotional health. In a study conducted during the first week postpartum in rural India, 7.4% of the mothers suffered from severe anaemia and 46.0% suffered from moderate anaemia[3]. In this study, the most common recommendation during the home visits was ferrous sulphate intake as observed by the MS for women without diagnosed anaemia[9].

A significantly higher percentage of women who received prenatal care at the FHU also received home visits in the first week after discharge. Continuity is critical for the coordination and quality of care. It is therefore important to understand that continuity involves a relationship between health workers and users and that this tie can produce some insight into the concentration of home visits among the women who received prenatal care at the FHU alone. A meta-analysis found that continued care that starts in pregnancy and continues to childbirth and the postpartum is critical for the reduction of maternal and neonatal mortality[19].

The participants of this study did a postpartum review at the health service where childbirth occurred since some maternity hospitals offer this type of service. The finding that only 63.1% of the participants were informed of the need to have a puerperal appointment is suggestive of the puerperal limitations of continued care by the local team in the puerperium. A study conducted in Cuiabá, Mato Grosso do Sul, Brazil found that only 49.1% of 55 community health agents could systematically offer nursing appointments at the health service seven to ten days after delivery, and 49.1% previously scheduled the postpartum consultations[20].

FINAL CONSIDERATIONS

The results reveal the technical, ethical, and organisational limitations of the health practices performed by the FHS teams during home visits in the puerperium. The healthcare provided to women after childbirth lacks critical activities, especially those related to breastfeeding. These findings stress the importance of providing care that observes the biological needs and social role of mothers, instead of considering the specific demands of women as secondary. Furthermore, there is a tendency to rationalise mother and child care. Regardless, home visits in the first week after discharge were positively assessed by the participants, which shows that these users have low expectations of the public health services.

The operationalisation of home visits is based on puerperal references that workers use to support their duties. The systematic and participatory planning of goals, strategies and actions, permanent education, and the continued evaluation of activities and work processes recommended by the MS are essential to address these problems and prepare team members to perform their roles and responsibilities in the puerperium. This performance affects maternal and perinatal morbidity and mortality, and the quality of life of women who have recently given birth.

Further reflection on local practices and the contexts in which they are applied expands the perception of learning and organizational needs. This perception is essential to correctly outline the changes required during work. Efforts are also needed to improve the quality of the organisational structure of postpartum care at the FHU. Management is strategic for the translation of policies into concrete forms of organising health actions.

The main research limitations were the size of the sample, although it allowed for acceptable accuracy and managed to provide the support needed to plan actions in the puerperium, and the fact that the study population was restricted to recent mothers who had access to the postnatal review. Nevertheless, the results of this study can support further research and nursing education and practice in terms of communication and technical integration in the work of the interdisciplinary team, the importance of dialogue between health professionals and users, and to define lines of care for each situation.

REFERENCES

1. World Health Organization (CH). Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division [Internet]. Geneva: World Health Organization; 2014 [cited 2015 Apr 21]. Available from: http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1.
2. Assarag B, Dubourg D, Maaroufi A, Dujardin B, De Brouwere V. Maternal postpartum morbidity in Marrakesh: what women feel what doctors diagnose? BMC Pregnancy Childbirth. 2013 [cited 2015 Jan 20];13:225. Available from: http://www.biomedcentral.com/1471-2393/13/225.
3. Iyengar K. Early postpartum maternal morbidity among rural women of Rajasthan, India: a community-based study. J Health Popul Nutr. 2012 [cited 2015 Feb 15];30(2):213-25. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3397332/pdf/jhpn0030-0213.pdf.
4. Morse ML, Fonseca SC, Barbosa MD, Calil MB, Eyer FPC. Mortalidade maternal no Brasil: o que mostra a produção científica nos últimos 30 anos? Cad Saúde Pública 2011;27(4):623-38.
5. Yonemoto N, Dowswell T, Nagai S, Mori R. Schedules for home visits in the early postpartum period (Review). Evid Based Child Health. 2014 [cited 2015 Feb 15];9(1):5-99. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009326.pub2/epdf.
6. Olds DL, Kitzman H, Knudtson MD, Anson E, Smith JA, Cole R. Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow-up of a randomized clinical trial. JAMA Pediatr. 2014 [cited 2015 Mar 13];168(9):800-6. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235164/pdf/nihms640983.pdf.
7. Correa MS, Feliciano KV, Pedrosa EN, Souza AI. Women's perception concerning health care in the post-partum period: a meta-synthesis. OJOG. 2014 [cited 2015 Jan 15]; 4:416-26. Available from: http://dx.doi.org/10.4236/ojog.2014.47062.
8. Ministério da Saúde (BR), Secretaria de Atenção à Saúde. Política Nacional de Atenção Básica. Brasília (DF); 2012.
9. Ministério da Saúde (BR), Secretaria de Atenção à Saúde. Pré-natal e puerpério: atenção qualificada e humanizada – manual técnico. 3. ed. rev. Brasília (DF); 2006.
10. Contandriopoulos AP, Champagne F, Denis JL, Pineault R. A avaliação na área da saúde: conceitos e métodos. In: Hartz ZMA, organizador. Avaliação em saúde: dos modelos conceituais à prática na análise da implantação de programas. Rio de Janeiro: Fiocruz, 1997. p. 29-47.
11. Sitrin D, Guenther T, Murray J, Pilgrim N, Rubayet S, Ligowe R, et al. Reaching mothers and babies with early postnatal home visits: the implementation realities of achieving high coverage in large-scale programs. PLoS ONE. 2013 [cited 2015 Jan 20]; 8(7):e68930. Available from: http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0068930&representation=PDF.
12. Ehrentha DB, Maiden K, Rogers S, Amy Ball BA. Postpartum healthcare after gestational diabetes and hypertension. J Women's Health. 2014;23(9):760-4. doi: http://dx.doi.org/10.1089/jwh.2013.4688.
13. Haire-Joshu DL, Schwarz CD, Peskoe SB, Budd EL, Brownson RC, Joshu CE. A group randomized controlled trail integrating obesity prevention and control for postpartum adolescents in a home visiting program. Int J Behav Nutr Phys Act. 2015;12:88. doi: http://dx.doi.org/10.1186/s12966-015-0247-8.
14. Organização Mundial de Saúde (CH). Declaração da OMS sobre taxas de cesáreas. Genebra; 2015. [citado 2015 ago 15]. Available at: http://apps.who.int/iris/bitstream/10665/161442/3/WHO_RHR_15.02_por.pdf.
15. Corrêa MSM. Cuidado no puerpério: percepções e práticas de mulheres e da equipe de saúde da família [tese]. Recife (PE): Pós-graduação em Saúde Materna e Infantil, Instituto de Medicina Integral Prof. Fernando Figueira; 2015.
16. Kebian LVA, Acioli S. A visita domiciliar de enfermeiros e agentes comunitários de saúde da Estratégia Saúde da Família. Rev Eletr Enf. 2014;16(1):161-9. Available at: http://dx.doi.org/10.5216/ree.v16i1.20260.
17. Cunha MS, Sá MC. A visita domiciliar na Estratégia de Saúde da Família: o desafio de se mover no território. Interface – Comunic, Saude, Educ. 2013;17(44):61-73.
18. Bernardi MC, Carraro TE, Sebold LF. Visita domiciliária puerperal como estratégia de cuidado de enfermagem na atenção básica: revisão integrativa. Rev Rene. 2011;12(nesp.):1074-80.
19. Kikuchi K, Ansah EK, Okawa S, Enuameh Y, Yasuoka J, Nanishi K, et al. Effective linkages of continuum of care for improving neonatal, perinatal, and maternal mortality: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0139288. doi: http://dx.doi.org/10.1371/journal.pone.0139288.
20. Oliveira DC, Mandú ENT, Corrêa ACP, Tomiyoshi JT, Teixeira RC. Estrutura organizacional da atenção pós-parto na Estratégia Saúde da Família. Esc Anna Nery. 2013;17(3):446-54.

Corresponding author:
Ariani Impieri Souza
E-mail: ariani@imip.org.br

Received: 10.09.2015
Approved: 09.19.2016