http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI: 10.4025/cienccuidsaude.v20i0.55440

ORIGINAL ARTICLE

THE LIVING OF WOMEN IN THE PUERPERAL PERIOD: (DIS)CONTINUITY OF CARE IN MATERNITY AND PRIMARY CARE

Marcia Aparecida dos Santos Silva Canario*
Alexandrina Aparecida Maciel Cardelli**
Sebastião Caldeira***
Adriana Valongo Zani****
Maria Aparecida Baggio*****
Rosangela Aparecida Pimenta Ferrari******

ABSTRACT

Objective: To understand the experience of women regarding the continuity of puerperal care in primary health care, in municipalities in the State of Paraná, guided by the Rede MãeParanaense. **Method**: This is qualitative research using Alfred Schütz's theoretical-methodological framework, carried out through semi-structured interviews with 23 women, in four municipalities of a Regional Health in the State of Paraná, Brazil, between March and September of 2018. **Results**: Three categories were identified: 1) Immediate puerperium: preparation for maternity discharge and care in primary health care; 2) Late puerperium: continuity of care for women in primary health care. 3) Care in the puerperal period in primary health care: maternal expectations. **Conclusion**: The cities under study still do not offer systematic monitoring of women's health in the puerperal period, resulting in a low resolution, access, and completeness, which consequently leads to exposure to the greater risk of injuries in the puerperium due to restricted promotion actions and prevention by health professionals.

Keywords: Women´s health. Postpartum period. Primary health care. Delivery of health care.

INTRODUCTION

The Pan American Health Organization (PAHO) emphasizes the importance of care before, during, and after childbirth, which can save the lives of women and newborns. Hypertension, hemorrhages, infections, complications in childbirth, and unsafe abortions are among the main causes of maternal deaths, particularly in developing countries. Therefore, the adequate evaluation of the woman, also in the postpartum period (puerperium), can prevent death from events associated with this period. Thus, women need access to skilled care and services in the weeks after delivery. Furthermore, barriers that limit this access need to be identified and resolved at all levels of maternal health care[1].

In Brazil, advances in maternal health care are represented by policies and programs such as the Integrated Assistance Program for Women's Health (PAISM), created in 1984[2], the National Policy for Integral Attention to Women's Health (PNAISM), in 2004[3], *Rede Cegonha*, in 2011. The *Rede Cegonha* included the puerperium as a period that deserves special attention from health services, with quality, humanized, and resolute care, in the context of Primary Care in Health (PHC)[4].

In Paraná, in 2012, the *Rede Mãe Paranaense* (RMP) was implemented as a model of maternal and child health care for access and promotion of safe and quality care during pregnancy, childbirth, puerperium and children under one year old. The actions involve the early recruitment of the pregnant woman, seven prenatal consultations and one puerperal consultation, at least, carrying out exams recommended by the RMP, risk stratification of pregnant women and children, specialized outpatient care, and connection to a hospital according to the stratification of gestational risk[5].

The puerperium is the period in which the woman returns to pre-pregnancy conditions and is classified as immediate (1st to 10th day), early

* Nurse. PhD in Nursing, Philadelphia University of Londrina, Londrina, PR, Brasil. E-mail: marcia.s.s.canario@gmail.com. ORCID iD: 0000-0002-2882-6184.
**Nurse. PhD in Nursing, Universidade Estadual de Londrina, PR, Brasil. E-mail: macielalexandrina@gmail.com. ORCID iD: 0000-0002-0222-8821
***Nurse. PhD in Sciences, State University of Western Paraná, Cascavel, PR, Brasil. E-mail: sebastiao.caldeira@unioeste.br. ORCID iD: 0000-0003-2827-1833.
**** Nurse. PhD in Collective Health, State University of Londrina, Londrina, PR, Brasil. E-mail: adrianazanienf@gmail.com. ORCID iD: 0000-0002-6656-8155.
***** Nurse. PhD in Nursing, State University of Western Paraná, Cascavel, PR, Brasil. E-mail: mariabaggio@yahoo.com.br. ORCID iD: 0000-0001-6901-461X.
******Nurse. PhD in Sciences, State University of Londrina, Londrina, PR, Brasil. E-mail: ropimentaferrari@uel.br. ORCID iD: 0000-0003-0157-7461.

(11thto 42ndday) and remote from the 43rdday until one year after delivery[6]. During this period, the puerperal woman experiences sudden physical changes in her body while she needs to meet the needs of a new human being who mainly depends on her care[7].

Motherhood is an event of transformation, which goes beyond the expectations of pregnancy and becomes one of the most peculiar moments in the existence of human beings. The physical, emotional, and social changes in this period lead to a biologically determined phase of change, which culminates in birth[8].

The changes in the puerperium require adaptations by women and their families. The familyis considered a support network to respond to maternal changes inherent to the period, in a positive way[9]. The puerperium affects not only the mother's relationship with her child, but it also affects social and family relationships, whose period is considered the greatest developmental effect that a woman experiences throughout her life[10]. However, the vulnerability and ineffective responses of this network can harm maternal health and compromise the mother-infant bond[11].

In this context of postpartum and family adaptations, health professionals can offer clinical assessment and qualified care, in addition to technical procedures, through qualified listening and meeting the postpartum women's biopsychosocial needs and family demands. Adequate support can allow adequate continuity of care for this woman, who is faced with new roles assumed in the experience of motherhood[12], which involves what is experienced from the intersubjective relationships with other individuals in the social world and in the care and assistantscenarios to the woman who is experiencing the puerperium[13].

Therefore, the question is: what is the experience of women regarding the continuity of puerperal care in primary health care (PHC)? Therefore, the study aimed to understand the experience of women regarding the continuity of puerperal care in PHC, in municipalities in the State of Paraná, guided by the *Rede Mãe Paranaense*.

METHOD

This is qualitative research using the theoretical-methodological framework of Social Phenomenology, by Alfred Schütz[13], with the participation of 23 women living in four municipalities (M1, M2, M3, and M4), of the 21 that make up the 17th Regional Health Department of the State of Paraná. The study was carried out from May to September 2018.

Municipalities M1, M2, and M3 are medium-sized and each has a maternity ward for normal-risk childbirth (NR) by the Unified Health System (SUS), a reference for another 11 municipalities. Municipality M4 is large and has two maternity hospitals that assist the SUS, one for NR, a reference for two cities, and a maternity hospital for High Risk (HR), which assists 21 cities in the Regional and neighboring states.

The mothers participated in the study by availability for a home visit, previously scheduled by telephone, between the 30thand 42nd days after delivery, with awareness and signing of the Informed Consent Form for the interview recorded on audio media. We included in the research women classified as Normal Risk and High Risk who lived in the municipality of the maternity hospitals of this study and who, after discharge, used PHC.

For the recorded interview, a script with semi-structured questions extracted from the RMP matrix was used: “Have you heard about the *Rede Mãe Paranaense* Program? Tell me what you know from your experience (What is it for you?)”; “At hospital discharge, after delivery, did you receive any guidance on which health service to seek for the continuity of your care? Comment”; “Did you receive a visit from the health team in the first week after delivery?; Tell me about this visit”; “After being discharged from the maternity hospital, tell me how was your follow-up at the health service in the 1stmonth after delivery”; “What do you expect from services, public policies and programs aimed at care in the puerperal period?”; "What do you expect from your city/regional/state (politicians) regarding puerperal care?" and, finally, “Would you like to talk about something that was not covered in the previous questions in this interview?”.

The average interview time was 50 minutes,

considering the researcher's interaction with the participant and ended by the convergence of the "reasons why" and "reasons for", enabling the constitution of the type experienced[13] in the care of the mother in the service of PHC after discharge from the maternity hospital, according to the adopted theoretical framework.

Alfred Schütz's Social Phenomenology, also called Phenomenological Sociology or Comprehensive Sociology, uses concepts such as lifeworld, intersubjectivity, the body of knowledge, and motivation, as the individual acts through existential reasons that, added to the lived experience, externalizes actions driven by "reasons why" and "reasons for"[13]. These actions are behaviors that result in a certain end and the "reasons why" are the reasons for this individual's personality and for the learning he has accumulated throughout his life. The "reasons for" direct future and subjective actions, apprehended when there is a question about the meaning of these actions[13-14].

The material resulting from the interviews was transcribed in full and then checked and organized by two researchers, following the six steps of the framework[13]: attentive and careful reading of each statement, to identify and apprehend the global meaning of the social action; individual re-reading of statements to identify common aspects that express the contents related to "reasons why" and "reasons for"; a grouping of convergences to extract concrete categories; analysis of concrete categories for understanding social action; from the set of "reasons why" and "reasons for" the lived type expressed in concrete categories and discussed in the light of the theoretical-methodological framework, as well as other references relevant to the object of study, was constituted.

For the confidentiality of the participants, they were identified with the letter P (new mother) followed by an Arabic number (n) in the order of the interviews, risk characterization (NR and HR), and the municipality (M1, M2, and M3 - Medium Size; and M4 – Large size), is noted as follows: Mnº NR-M1 or M2 or M3 or M4 or Mnº HR-M4. The research was authorized by the Health Department of the State of Paraná, Regional Health Board, and Maternity Boards of each municipality, as well as approved by the Ethics Committee for Research with Human Beings of the State University of Londrina, opinion number 2,053,304 and CAAE: 67574517.1.1001.5231.

RESULTS

Twenty-three women participated in the research, of which 14 were classified as High Risk and 9 as Normal Risk. As for the age group, they were between 15 and 37 years old, with more than half of them have completed high school (complete or incomplete), the majority (20) lived with a partner, thirteen were primiparas, and ten multiparas.

Maternal reports enabled to apprehend the meanings of life after childbirth and return home and are presented in three categories, two of which translate the "reasons why": Immediate puerperium: preparation for discharge from maternity and care in primary health care; Late puerperium: continuity of care for women in primary health care. The "reasons why" and expectations in a third category: Care in the puerperal period in primary health care: maternal expectations.

Immediate puerperium in the Network: preparation for maternity discharge and care in primary health care

This category refers to what women know about RMP, the counter-referral of mothers by maternity hospitals to PHC, insufficient guidance provided by professionals, and the follow-up of women in PHC in the immediate puerperal period.

We observed in the speeches that women were not informed by professionals about the RMP. Those who knew received specific information during prenatal care.

> [...] Actually, I didn't know that this program existed, so when I went to do prenatal care, they found that I had high blood pressure. I remember that the girls [nurses] said they would refer me to the Rede Mãe Paranaense. That's what I heard from them at the health center. I think it's a program, like that, that all women [...] could have access to, and from what I've seen [...], only those with high-risk pregnancies [...] because the follow-up is very complete [...]. I had the right to several exams, consultations, and ultrasounds, all

> for free. I liked it and thought it was very important [...] (P2 HR-M3).
>
> [...] I was referred there [RMP] [...]. It is the follow-up for high-risk pregnancy [...] (P4 NR-M3).
>
> [...] No, I have never heard of {the RMP} [...] (P5 NR-M3).
>
> [...] No, only in the hospital [...] this is what the researchers do [...]. In the prenatal period, I didn't know anything [about the RMP] [...] (P15 HR-M4).
>
> [...] Not a lot [...]. I don't have much information [about the RMP] [...] (P16 NR-M4).
>
> [...] at the beginning of the follow-up, the doctor told me [about the RMP] [...] (P23 HR-M1).

When comparing the speeches of women who had babies in Hospitals of Normal Risk (NR) with those of High Risk (HR), we observed that in both the guidelines transmitted about the puerperal period were little explored and dispersed. According to the reports, the information transmitted to the puerperal women was not standardized and most of the mothers were not directed to the PHC service for the continuity of care in the immediate puerperium.

> [...] they referred me to the Hospital de Clinicas (HR outpatient clinic) to follow up there [...] I am doing it until today (P11 HR-M4).
>
> [...] He advised that the stitches were to be removed at the hospital [...] (P13 NR-M4).
>
> [...] they told me to look for the health center to continue the follow-up. To go through the gynecologist after a while (P2 HR-M3).
>
> [...] If I had pain, swelling, and redness in the stitches, I should go back to the hospital[...] (P20 HR-M1).

In the immediate postpartum period, not all PHC units carried out home visits, regardless of whether the woman is considered NR or HR, in both medium-sized and large municipalities, as shown in the following reports:

> [...] The CHA and the nurse came [...] they asked me to see how I was breastfeeding, then I showed them [...]. I showed them how the surgery was. [...] I don't even leave the house to make an appointment for a doctor, they have already brought it scheduled [...] (P1HR-M3).
>
> [...] None [home visit], no one from the health unit has ever visited or even called [...] (P2 AR-M3).
>
> [...] I guess so. I think the Community Health Agent came [...] (P8 HR-M3).
>
> [...] I did not receive [home visits from the health team] [...] (P 11 HR-M4).
>
> [...] In the first week, no, because I was discharged on Sunday, and I went to the health unit on Monday [...] (P16 NR-M4).

Women who received a home visit in the immediate postpartum period reported having received an evaluation by a health professional. However, their reports showedthey had a brief and poor-quality evaluation. The evaluation of women, for the most part, was restricted to an inspection of the skin and mucous membranes, breasts, bleeding, and surgical points.

> [...] he looked at how my breasts were, he looked at the cesarean section, and the bleeding (P10 HR – M4).
>
> [...] she examined me and said that I was very yellow, very pale, then they asked me for blood tests [...] then she came back the other day to bring the test result, and examine me again […]. As there was nothing changed, they only guided me so that I could eat better (P17 NR-M4).

We found that the focus of the puerperal visit at home excludes the woman and prioritizes the newborn, whose care does not include all the aspects of assessment and care required in the home consultation. There were few guidelines regarding breastfeeding. This was true for either the mother-infant dyad of NR or HR. No differences were found in medium and large cities.

> [...] The community agent came [...] she asked [...] how the delivery had been, if there had been any problems, any complications [...] (P7 NR – M3).
>
> [...] Just from the health unit, I don't know what she is, she had a blue coat, she came to see my son [...] but that's it, very quickly (P9 HR – M4).
>
> [...] three girls came [...] they came to see if everything was ok with the baby [...] examined her but did not examine me (P12 HR – M4).
>
> [...] a nurse came [...] she came here, asked me if everything was all right if he was breastfeeding [...] then she said I should be going to the clinic to schedule his first childcare [...] she did not examine him and neither did I [...] (P15 HR –

M4).

> [...] Yes, but they only examined the baby and guided me to look for the UBS (Basic Health Unit) if she needed it [...] (P23 HA – M1).

Remote puerperium: continuity of women's care in primary health care

This category addresses the experience of women in medical consultations with the gynecologist of the PHC service in the remote puerperal period. We observed that there was no mention of home visits or follow-up by the multidisciplinary team after discharge from the maternity hospital.

Regarding the care provided in the remote puerperal period, some of the medical evaluations were restricted to the examination of the surgical incision, the breasts, and the prescription of contraceptives. Guidance on breastfeeding was rarely addressed during consultations with the specialist.

> [...] the doctor asked how the surgery was [...] he asked if I had the tubal ligation
>
> [...] then I replied that this time I did it, then he said: so [...] I won't even give you medication. [...] he also evaluated the cesarean section and breasts [...] (P1 HA-M3).
>
> [...] the gynecologist talked to me about the issue of breastfeeding, if he was ok [...] issue of cesarean [...] then as I was already sterilized, he did not schedule another appointment [...] (P7 NR -M3).
>
> [...] I went through an appointment with the obstetrician again to see if everything was right [...] The doctor examined the uterus, the stitches [...] He gave birth control, and said that after the 5th month he could stop taking this one and go back to the old one I already took or consult with him, for him to prescribe another one [...] (P8 HR-M3).
>
> [...] I consulted the gynecologist then she gave me a contraceptive that I can take while I'm breastfeeding [...] now I'm waiting for the next appointment [...] (P19 NR-M4).

The following statements express the mothers' frustration regarding medical appointments. We noted that the physical examination is ignored, while the prescription and guidance of contraception seem to have greater relevance when compared to other assessments and guidance about the puerperium.

> [...] I went to the gynecologist, but [...] his way of being dry, he didn't even touch me; he asked if I was okay, how I was feeling if I was breastfeeding, asked a lot of questions, and prescribed me a contraceptive, and that was the appointment. At no time he did not touch me to check [...] if the uterus was in place, at no time did he do it [...] (P2 HR-M3).
>
> [...] I had an appointment with a gynecologist 20 days postpartum, but he didn't assess me, he only gave me oral medication[...] (P22 HR-M1).
>
> Almost all postpartum women did not receive a home visit for evaluation after discharge from the maternity hospital, that is, 21 of them. In some speeches, the continuity of puerperal care depends on the search for the PHC service, by the woman herself, or she remains unattended in both risk classifications. For the continuity of care for the puerperal woman, the geographical distance between the home and the health service was one of the obstacles.
>
> [...] I didn't see it, they didn't say anything [...] my medical record was sent to another clinic, because of the doctor [...] a clinic very far away and me with a baby, it's difficult to go […] (P6 HR-M3).
>
> [...] I didn't need assistance [...]. I went on my own to see which contraceptive to take [...] (P14 HR-M4).
>
> [...] I didn't have a consultation after the birth[...] (P16 NR-M4).

When there was an appointment at the health unit, the woman was unable to be seen due to the prolonged waiting time for the doctor, and also ended up not being welcomed by the nursing team, who could have carried out the puerperal consultation. Consequently, she was left without a contraceptive method.

> [...] They made an appointment with the gynecologist for 1:00 pm, and it was 3:30 pm and he hadn't arrived yet. Then, as I didn't want to take her because she was little the first time, she started crying to be fed and I left; I rescheduled the appointment, he was more than two hours late again, then I said I wouldn't go anymore [...] I'm not using contraceptives [...] (P4 NR-M3).

Care in the puerperal period in primary health care: maternal expectations

Expectations reveal what women experienced in the puerperal period and what they expect as a continuity of care in the puerperium by health professionals, which consequently reflects on the perception of its quality.

The women expressed their needs in the puerperal period and suggested that care should be focused on caring for the process of communication and professional-puerperal interaction to deal with this moment. They indicated the need for guidance and care regarding breastfeeding and reproductive planning, especially for mothers experiencing their first motherhood.

> [...] I think I had to pay more attention to the mother [...] that there are groups to explain breastfeeding [...] (P2 HR-M3).

> […] more attention, communication, and conversation [...] (P6 HR-M3).

> [...] more guidance on family planning (P7NR-M3),

> [...] total attention, because the mother doesn't know anything, even when my son cried in my lap, the first time, I didn't even know what to do [...] (P9 HA-M4).

Another expectation in the speeches of the participants involves the qualification of professionals who care for women in the puerperal period, as well as the availability of gynecologists in health units, as those who have them do not meet the needs of the population, consequently, the rearrangement is to seek private assistance.

> [...] I think it needs more professionals [...] the service has it, but it depends on the person[...] (P5 NR-M3).

> […] sending more doctors here [health unit] [...] (P6 HR-M3).

> [...] I needed a doctor, who is not available at the clinic [...] if you want to see a gynecologist, you have to pay because there is not a gynecologist at the clinic and there is no forecast of when a gynecologist will come [...] (P11 HR-M4).

The divergence between the prenatal program and the puerperal follow-up was identified, as in one the woman is systematically assisted and, in another, the follow-up is abandoned.

> [...] to do more exams [...] after delivery, for both mother and child. [...] we do the exam just before the birth [...] afterward you do nothing, you just go with the gynecologist, that's all [...] (P10 HR-M4).

DISCUSSION

The RMP[5] in its body of actions does not contemplate that it is up to health professionals to inform women about which health program or policy is based on their assistance. This can justify the educational gap identified in the testimony of the mothers who are unaware of the RMP, although this action may come from the professional. On the other hand, the RMP recommends that postpartum reproductive planning actions and guidelines start at the time of hospital discharge, in addition to referral to the puerperium consultation in the PHC, to guarantee the continuity of care; however, we found them fragile in this study.

In the transition from hospital to home, postpartum women, especially primiparous women, have a greater need for security for self-care and the performance of the role of mother[15]. In this sense, it is the responsibility of the PHC health professional to carry out a home visit in the first week after delivery to ensure access to reproductive planning, assess the clinical and emotional conditions of the puerperal woman, encourage breastfeeding and encourage confidence for self-care and the newborn care[5,16]. However, we verified that the home visit is mainly focused on the clinical aspects of the puerperium.

PHC professionals, from both medium and large cities, did not carry out home visits for all postpartum women, as recommended by the MH and the RMP[5,16]. When performed, the assessment of the mother and the context surrounding her was not identified, in an individualized perspective, but in a technical way, which assessed breasts, bleeding and/or surgical wound, depriving women of care regarding their emotional condition, self-care, adaptation to the life of mother and woman after childbirth[15,17]. The clinical assessment, focused on the risk of potential complications, is necessary to reduce maternal mortality rates[1], but the professional's broader perspective qualifies the assistance beyond that.

Therefore, in this study, the home visits show

an incipient welcoming process, devaluation of the specific needs of postpartum women, lack of physical examination and anamnesis, insufficient guidance, and limited communication between professionals and postpartum women[18-19].

Such evidence refers to a low technical quality of puerperal care, whose data is related to a meta-synthesis study[19], in which the puerperal women expressed dissatisfaction with the care of their needs, mainly due to the focus on the baby, inattention to primiparas and clinical approach fragile. Therefore, postpartum care is primarily focused on the care of the newborn and not the woman[12].

The distance between the residence and the health service and the excessive waiting time for the consultation to take place constitutes a barrier to guaranteeing postpartum follow-up[20]. In this study, these factors contributed to not having the first puerperal consultation, in the first week after delivery.

In the absence of home visits by health professionals in the first week after delivery and an appointment for the puerperal woman in the PHC, there was a woman's search for self-care, which can be perceived as a positive aspect of self-care. In this case, she demonstrates that she takes responsibility for her care, which in the remote postpartum period may be related to the woman's age, social insertion, and beliefs[21].

Regarding the encouragement of breastfeeding during the puerperal consultation, this practice was rarely performed by professionals. However, in the puerperium, the nursing mother needs guidance, support, and assistance from a qualified professional, since during this period the main difficulties appear, such as insufficient or excess milk, engorgement, and breast fissures, among others[9].

Due to the medical-centric view of care, and because they lack knowledge about the RMP and their rights, women's expectations revolve around having more gynecologists and exams for their follow-up to meet their needs and receive quality care. These women have interests that are their own, which direct them to seek care in the health sector[13-14]. Therefore, this group of women can be typified as the one who expects, during the puerperium, health professionals to provide comprehensive and equitable care in different aspects, fulfilling the objectives and guidelines of the RMP.

According to the results, it is necessary that professionals and managers of health services, at all levels of care, invest in continuing education for a greater professional qualification, aimed at complying with ministerial and regional guidelines on women's healthin the puerperium. We should incorporate these strategies into the academic training of health professionals as well. The search for excellence in postpartum care is emerging, based on the humanization, reception, and resolvability of health care in primary care.

The study was limited to investigating the experience of women regarding the continuity of puerperal care in PHC, in only four municipalities of the 17thRegional Health Department of the State of Paraná, whose results cannot be generalized. However, they can also be present in other realities and deserve to be carefully observed by health professionals and managers to qualify the care for women in the puerperium.

CONCLUSION

The woman's experience regarding the continuity of puerperal care in PHC showed weaknesses, such as incipient home visits; scarce physical examination, and anamnesis, which mainly considers the evaluation of breasts, bleeding, and surgical wound; the focus of attention on the newborn and not on the woman. The assistance of health professionals is not focused on adequate guidance and on meeting the specific needs of the woman who is experiencing the puerperium, in her particularity.

Women expect that, in the puerperal period, professionals have as their main focus their needs in the period, particularly primiparous women, with greater attention, communication, and professional interaction. Care and guidance regarding breastfeeding and counseling on reproductive planning were indicated as necessary to qualify the assistance.

Finally, it appears that the cities under study still do not offer systematic monitoring of women's health in the puerperal period, culminating in low resolution, access, and completeness, which consequently leads to

exposure to the greater risk of injuries in the puerperium due to restricted promotion and prevention actions by health professionals.

We expect that this study can support health professionals and managers focused on women's health care with information, reflections, and actions that strive for quality and resolvability of care for women, in the puerperal period, in PHC.

O VIVIDO DE MULHERES NO PUERPÉRIO: (DES)CONTINUIDADE DA ASSISTÊNCIA NA MATERNIDADE E ATENÇÃO PRIMÁRIA

RESUMO

Objetivo: compreender a vivência da mulher quanto à continuidade da assistência puerperal na atenção primária à saúde, em municípios do estado do Paraná, orientados pela Rede Mãe Paranaense. **Método:** trata-se de pesquisa qualitativa com uso do referencial teórico-metodológico de Alfred Schütz, realizada por meio de entrevista semiestruturada, com 23 mulheres, em quatro municípios de uma Regional de Saúde do Estado do Paraná, Brasil, entre março e setembro de 2018. **Resultados:** identificaram-se três categorias: 1) Puerpério imediato: preparo para a alta da maternidade e cuidado na atenção primária à saúde; 2) Puerpério tardio: continuidade do cuidado à mulher na atenção primária à saúde; 3) O cuidado no período puerperal na atenção primária à saúde: expectativas maternas. **Conclusão:** os municípios em estudo ainda não oferecem um acompanhamento sistemático da saúde da mulher no período puerperal, culminando para a baixa resolutividade, acesso e integralidade, o que consequentemente remete para a exposição ao maior risco de agravos no puerpério devido às restritas ações de promoção e prevenção pelos profissionais de saúde.

Palavras-chave: Saúde da Mulher. Período Pós-parto. Atenção Primária à Saúde. Assistência à Saúde.

LA EXPERIENCIA DE MUJERES EN EL PUERPERIO: (DES)CONTINUIDAD DE LA ASISTENCIA EN LA MATERNIDAD Y ATENCIÓN PRIMARIA

RESUMEN

Objetivo: comprender la vivencia de la mujer en cuanto a la continuidad de la asistencia en el puerperioen la atención primaria de salud, en municipios del Estado de Paraná/Brasil, orientados por la *Rede Mãe Paranaense*. **Método:** se trata de una investigacióncualitativa con uso del referencial teórico-metodológico de Alfred Schütz, realizada por medio de entrevista semiestructurada, con 23 mujeres, encuatro municipios de una Regional de Salud del Estado de Paraná, entre marzo y septiembre de 2018. **Resultados:** fueron identificadas tres categorías: 1) Puerperio inmediato: preparación para el alta de la maternidad y cuidado en la atención primaria a la salud; 2) Puerperio tardío: continuidad del cuidado a la mujer en la atención primaria a la salud. 3)El cuidado en el período puerperal en la atención primaria a la salud: expectativas maternas. **Conclusión:** los municipios estudiados aún no ofrecen un acompañamiento sistemático de la salud de la mujer en el período puerperal, culminando para la disminución de la resolución, del acceso yla integralidad, lo que consecuentemente remete para la exposición al mayor riesgo de agravios en el puerperio debido a las restrictas acciones de promocióny prevención por los profesionales de salud.

Palabras clave: Salud de la mujer. Periodoposparto. Atención primaria de salud. Prestación de atención de salud.

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Corresponding author: Rosângela Aparecia Pimenta Ferrari. Av. Robert Kock, n. 60, Vila Operária, Health Sciences Center, Nursing Department/UEL, 3rd floor, CEP: 86038-350, Londrina-PR. E-mail: ropimentaferrari@uel

Submitted: 27/12/2020
Accepted: 01/08/2021

FINANCIAL SUPPORT

Universal Notice MCTI/CNPq No. 01/2016