

**EARLY POSTPARTUM REVIEW:  
Analysis of the Programmatic Actions Offered In Primary Health Care**

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**ABSTRACT**

*The postpartum review aims to reduce the incidence of injuries and in addition its implementation in primary care which has not been consolidated yet. This study examined the programmatic actions offered to women in immediate postpartum in Londrina, Brazil. Cross-sectional study nested in a prospective cohort study with 358 postpartum women who underwent early ambulation and home postpartum review in primary care, between July 2013 and March 2014. A documentary data transcription technique, prenatal and childbirth; non-participant observation in the Lucilla Ballalai Municipal Maternity Clinic and a structured interview at home after 42 days postpartum were used. The univariate analysis and chi-square test ( $p \leq 0.05$ ) were used. There was association among guidance about childbirth in prenatal care ( $p \leq 0.036$ ), the type of birth ( $p \leq 0.002$ ) and the dependent variable. It was evidenced elements of the programmatic vulnerability such as the fragmentation of the health service organization, access barriers and low quality care. There is a need for revisiting the program actions for the avoidance of unnecessary costs for duplication of actions and lack of others.*

**Keywords:** Health public policies. Women's health. Postpartum period. Health vulnerability. Home visit

**1. INTRODUCTION**

In Brazil, the women's health public policies are evolving since the 80s and had as precursor the Integral Assistance Program for Women's Health (PAISM). Currently, the "Rede Cegonha" was established and proposes to carry out care to ensure women the right to reproductive planning and humanized attention to pregnancy, childbirth and the postpartum period and to the child, the right to safe birth and healthy growth and development (Giovanni, 2013; Morais, 2013).

The introduction and implementation of health policies in progress in primary care are put into operation by the Family Health Strategy called ESF that seeks to reorient the hegemonic care model, combining individual and collective actions on health promotion and disease prevention of a given population by the inclusion of multidisciplinary teams in Basic Health Units called UBS (Nascimento, 2014). Despite the unremitting efforts in the execution of actions and programs,

the attention to women's health is fragmented and little resolute. Most women still find barriers to access and connection with health services, supporting high rates of maternal morbidity and mortality (Ministério da Saúde, 2012a).

Integrating this scenario is the postpartum period, usually neglected when compared to pregnancy and childbirth (World Health Organization [WHO], 2010). This period provides health professionals opportunities to identify, monitor and manage risk situations or incidents and lead it (Khanal, Adihikari, Karkee, & Garvidia, 2014), as well as performing and / or complement actions resulting from prenatal (Oliveira, Quirino, & Rodrigues, 2012). Thus, the access and quality of care provided are crucial in the promotion and maintenance of health and prevention of injuries to both the mother and son (Angelo & Brito, 2012).

According to the World Health Organization (WHO), the postpartum period is defined as the period starting shortly after the child's birth and continues for six weeks after birth (World Health Organization [WHO], 2010). Its classification is divided into three stages, namely: the immediately postpartum, which corresponds to the period from the first to the tenth day; the late postpartum period, from the 11<sup>th</sup> to the 42<sup>nd</sup> day; and the remote postpartum, from 43<sup>rd</sup> day (Santos, Brito, & Mazzo, 2013).

Viewing the importance of postpartum in women's health, its assistance was recommended by the Ministry of Health in two stages, early postpartum review (between the 7<sup>th</sup> to the 10<sup>th</sup> day after birth) and the late postpartum review (between 30<sup>th</sup> to the 42<sup>nd</sup> day after birth) (Prefeitura Municipal, 2006). In the context of primary health care, the ESF performs the early postpartum review through home visits, while the late postpartum review happens in UBS (Santos, Brito, & Mazzo, 2013).

However, in Londrina city there is a service that operates concomitantly with those listed in national and local programmatic actions. The postpartum ward, proposed and located in the Municipal Maternity Clinic of Lucilla Ballalai (MMLB) was created to minimize the gap of postpartum follow-up in primary care and get feedback of provided assistance in childbirth and in the ward unit. This service assists women who gave birth in the MMLB and emerged from the institutional need to reduce cases of infection in the postpartum period, readmission rates and the maternal mortality rate, besides providing care in breastfeeding, milk donation collection and family planning (Prefeitura Municipal, 2014).

The postpartum period can produce vulnerability in women, since it is a complex interleaving period and physiological, emotional, relational and social-cultural transition. The vulnerability, concept that transcends the idea of susceptibility or fragility, is something that brings together exposure and protection factors to this process, which can be individual, social and programmatic (Cabral, Hirt, & Van Der Sand, 2013).

The programs and health services must carry out the diagnosis of vulnerability and hence, elaborate intervention actions, mediating individuals and their social contexts in order to make them realize and overcome unfavorable conditions, transforming their relationships, values and interests to emancipate themselves from the vulnerabilities. However, when health institutions reproduce or accentuate the given social circumstances of vulnerability, the programmatic vulnerability befalls (Ayres, Calazans, Saletti Filho, & França-Júnior, 2006).

The programmatic vulnerability reflects, among other things, the organization, access and quality of health services. In this sense, for evaluating the postpartum period is essential to revisit the prenatal service and birth care, because these will determine the specific programmatic actions to the women's needs in the postpartum period. Based on these, this study aimed to analyze programmatic actions offered to women in immediate postpartum period.

## 2. METHODS

This is an analytical cross-sectional study nested in a prospective cohort. It was conducted with women in the immediate postpartum period, with normal and intermediate risk pregnancy diagnosis, residing in the urban area of Londrina city, assisted in the MMLB's postpartum ward and in their homes by the family health teams.

From a total of 3,415 births in the MMLB in 2012, a minimum sample size of 358 was estimated, to which 20% was added considering possible losses (N = 429). The data collection was carried out between July 2013 and March 2014 and began with the daily identification of mothers in the ward unit of the MMLB, using a convenience sampling.

Figure 1 shows the flowchart showing the follow-up of women in immediate postpartum period in Londrina / PR, stating the specific populations at each stage, sample losses, data collection periods, with their respective techniques and instruments used.

It is noteworthy that there was a period in which at the same time that the postpartum women were selected for the study, others were already being followed regarding the early ambulation postpartum review and / or receiving

home visits of the research team, after a period of 42 days after birth for rescuing the data relating to home early postpartum review.

The used instrument was structured with socioeconomic data, prenatal card, hospital records, the Early Ambulation Postpartum Review (EAPR) form, and issues regarding the Household Early Postpartum Review (HEPR). The data relating to prenatal followed the suitability proposal of this care based on Coutinho, Montiero, Sayd, Teixeira, Coutinho and Coutinho (2010) analyzing the prenatal booklet to classify the service as adequate, inadequate or intermediate. The instructions given in prenatal care in UBS, the interval between the last visit of prenatal and childbirth were also assessed.

Regarding the birth, the induction of labor, type of birth, intrapartum complications and perineum conditions were analyzed. In the postpartum ward was raised the EAPR enrollment; professional who provided the service; prenatal and child health booklet checking; use of medications; breastfeeding conditions; sleep and rest; psycho-emotional condition; relationship between mother and child; vital signs; clinical and gynecological evaluation; hygiene; guidance to the woman; weight, physical examination and guidelines for Newborn (NB); counter-primary care and scheduling of late postpartum review at UBS.

It is highlighted that the postpartum ward of the MMLB attends from Monday to Friday from eight a.m. to one p.m. About 12 women attend the maternity daily for early postpartum review that occurs in up to 10 days after birth. The service team is formed by an obstetric nurse, a nurse technician and a gynecologist. The consultations are carried out by the nurse daily, who has the support of medical evaluation three days a week, the other two days, if there is necessity, the evaluation is performed by the physician on duty. For control, the service has an agenda where it is registered the names and times that each postpartum woman will be attended and a reminder is attached in the child's booklet at the time of hospital discharge.

In Home Visit (HV) of the family health team rose variables about the guidelines at discharge; HEPR enrollment; professional who performed the HV; prenatal and child health booklet checking; use of medications; breastfeeding conditions; sleep and rest; psycho-emotional condition; relationship between mother and child; vital signs; clinical and gynecological evaluation; hygiene; weight and physical examination of the newborn; guidance to women and newborns; follow-up offered to the binomial in the UBS and satisfaction with the service received in the immediate postpartum period.

The variables of HEPR and EAPR were compared to programmatic actions proposed by MMLB and the Ministry of Health in accordance with the "First Week of Integral Health" based on the "Rede Cegonha" (Ministério da Saúde, 2012b).

The data was compiled in Microsoft Office Excel 2007 program and transported to the Statistical Package for Social Sciences (SPSS) program, version 20.0. The univariate analysis and the chi-square test to search for possible associations ( $p = 0.05$ ) between the independent variables and the dependent [type of assistance in immediate postpartum period] were used.

The study followed the determinations of the National Health Council Resolution 466/12 and it was approved by the Ethics Committee for Research Involving Human Beings of the State University of Londrina (CEP / UEL), CAAE: 19352513.9.0000.5231.

### 3. RESULTS

In the total of 429 postpartum mothers, the response rate was 83.44% ( $N = 358$ ). The social characteristics of women showed most young adults (78.8%) and high percentage of adolescents (21.2%). Almost all the total were living with their partners (84.1%) and had up to eleven years of education (92.5%); 60.1% were multiparous; 58.9% without legal employment and 68.1% had a family income of up to R\$ 1,399.00.

The adequacy analysis of prenatal care showed the classification of this service as intermediary (48%); inadequate (27%) and adequate (25%). During this service, the women reported having received guidance on labor signs (58%); 45% type of birth; 16% birth; and 86% of women reported guidance on the referral hospital for the child's birth; from these, 72% reported the MMLB, 61% mentioned the University Hospital, 4% were referenced to seek care in a private hospital.

The interval between the last prenatal appointment and birth ranged from zero to 15 days for most women (72.6%); 18.7% had a range between 16 and 30 days; and 8.7% more than 31 days. The women gave birth by vaginal access predominantly (75%); 42.7% had labor induced by oxytocin; 43.3% had intrapartum complications, and 32.6% of them did not receive the EAPR. The conditions of examined perineums were, in most, intact (57.5%); with first-degree tear (21.8%); with episiotomy (11.5%) and second-degree tear (9.2%).

At hospital discharge, 48% of postpartum women did not receive guidance on reference location for breastfeeding problems; 76% were not informed about the signs and symptoms of postpartum infection and 86% about bleeding. 84% of women were submitted to the primary health care.

Regarding the care received in the immediate postpartum period, it was observed that 28.2% of the women had the EAPR and HEPR; 34.1% only performed an EAPR; 19.5% received HEPR; and 18.2% had no follow-up (Table 1). Among women who did not receive any assistance in the immediate postpartum period, 23.1% were adolescents, 55.4% were between 20-29 years old and 21.5% 30 or more years old; 20% had up to seven years of study and 63.1% were housewives.

60.6% of women joined the EAPR, where 63.2% of attendances were performed by nurses, 27.1% by a doctor and a nurse and 9.7% only by the doctor. During this attendance, all women received care related to drug use, NB breastfeeding, sleep and rest, psycho-emotional condition, relationship between mother and child and the child's health booklet checking (Table 2).

Some cares were not offered to women, as verification of prenatal booklet (100%), for birth data, complications in childbirth and postpartum, HIV and syphilis test; the evaluation of the breastfeeding (94.6%); identification of breastfeeding problems (94.2%); risk of early weaning (15.9%); palpation of the abdomen (26.8%); the aspect of the surgical incision / episiotomy / perineum (17.8%); lochia (39.1%); guidance on breastfeeding (65.1%), self-care (76.7%); and the schedule for later postpartum review (100%). On the other hand, the family planning guidelines reached 95.3% of postpartum women. With regard to child care in the EAPR, there were no physical examination and weighing of the NB. There was guidance for child care and vaccine (83.3%) and care for the newborn (89.1%) (Table 2). Among these, 87.2% were related to heel prick, little heart, little ears and little eyes tests.

At the end of the ambulation care, the postpartum women's referral to the primary health care was performed, 3.5% of women were submitted to exclusive care to women; 30.6% to care of the binomial; 43.4% to care of the newborn and 22.5% did not receive a referral orientation.

With regard to HEPR in primary care, 52.3% of women reported not receiving this service. Among those who received the HV, 64.9% were attended by nurses, 19.3% by community health agents (CHA), 7% by nurse technicians, 5.8% by physicians and 3.0% by nurse residents.

In the HEPR, there was a lack of prenatal booklet checking; use of medications; breastfeeding of the newborn; breastfeeding difficulties; risk of early weaning, sleep and rest; psycho-emotional condition; relationship between the binomial; hygiene; vital signs; urinary and bowel habits; and self-care guidelines, family planning and care of the newborn (Table 2).

Among the cares not offered to postpartum women stood out the breastfeeding assessment (49.7%), breast condition (39.2%), palpation of the abdomen (53.2%), the aspect of the surgical incision / episiotomy / perineum checking (67.8%), lochia (67.8%), the breastfeeding guidance (49.7%) and the schedule of late postpartum review in the UBS (53.8%). The assistance focused on the NB revealed the lack of verification of the child's health booklet (23.4%), the physical examination (48.5%) and weight (80.7%), and the schedule for child care and vaccines (23.4%) (Table 2).

There was no association between socioeconomic variables and the type of assistance in immediate postpartum period. However, there was a statistically significant association with this type of birth ( $p \leq 0,002$ ) and the orientation on birth in prenatal ( $p \leq 0,036$ ). Among women who had not received any early postpartum review, 87.7% had spontaneous vaginal delivery and 12.3% had cesarean delivery (Table 3).

Regarding to the woman's satisfaction about the type of care received in immediate postpartum period, 84.8% reported being satisfied with the EAPR in the MMLB and 32.2% with the HEPR in primary health care.

#### 4. DISCUSSION

In this study we assessed the programmatic actions offered to women in immediate postpartum period, through organization-related elements, access and quality of health services, by comparing the actions observed in the postpartum ward of the MMLB and women's reports facing the actions offered in home visits.

The care offered after postpartum should be based on the obstetric history, in childbirth care and the real needs of women, newborns and their families. The quality of assistance in this period is important to adapt to the new reality, the difficulty overcoming and the creation of a relationship between mother and son, besides reducing the barriers that hinder women's access to health services, increasing their joining to programs inherent to the postpartum period.

In this context, it is understood that for evaluating the programmatic actions relevant to the immediate postpartum period, it was necessary to rescue the prenatal and childbirth care. The prenatal follow-up diagnosis showed dichotomy between the extensive coverage and the low care quality. The prenatal coverage of participants was effective, despite the service was classified as inadequate or intermediate. In a study conducted in the city of Rio de Janeiro revealed that only 38.5% of the women had an adequate prenatal care, according to parameters of the Program for Humanization in Prenatal and Birth called PHPN and that when only observed pregnancies to term, the adequacy percentage dropped to only 8.5% (Domingues, 2012). These data reflect the women's dropout right at the beginning the postpartum pregnancy cycle, because the coverage is not translated effectively into health care efficiency.

Another important diagnosis was the service gap between the last prenatal appointment and the delivery, revealing the obstacles in the continuity of the service for women among the stages involved in pregnancy and childbirth.

It is stressed that the execution of six or more appointment during pregnancy does not justify the dismissal of this follow-up, the "prenatal discharge" is seen as an undesirable practice that interrupts the continuity of care for pregnant women and indicates the fragility of prenatal care at the end of pregnancy (Figueiredo, Lunardi Filho, & Pimpão, 2012).

The occurrence of normal deliveries and small episiotomy practice showed respect to the diagnosis of normal and intermediate risk of these women, however, the number of cesarean deliveries was irrelevant. Cesarean delivery brings health risks to women and their child, increasing morbidity and maternal and neonatal mortality. The high degree of interventionism in Brazil is below the 15% stipulated by the World Health Organization (WHO) and according to DATASUS the cesarean rate in the country reached 53.88% in 2011 (Ministério da Saúde, 2011; Victora, Barreto, Leal, Monteiro, Schmidt, & Paim, 2011).

Even with the frequency of normal deliveries, the women in this study had complications related to the incidence of meconium, dystocia or progression failure and fetal distress. It should be noted the high use of oxytocin as the labor inductor. According to findings of Osava, Silva, Oliveira, Tuesta and Amaral (2012), there was a positive association between oxytocin infusion during labor and the presence of meconium in the amniotic fluid as well as the increase in the cesarean rate. The labor induction is also considered a risk factor for severe bleeding after delivery, which is the second leading cause of maternal death in the country (Martins, Souza, & Arzuaga-Salazar, 2013).

Several vulnerabilities have been identified by Cabral, Hirt and Van Der Sand (2013) in prenatal and childbirth care. These situations have given visibility to the programmatic vulnerability and some of them corroborated the findings of this study as the discontinuity of care and poor quality of prenatal service.

In this study, despite the favorable occasion to guidelines in hospital discharge because of the childbirth, these were low-dispersive, especially those related to breastfeeding, signs and symptoms of postpartum infection and bleeding. On the other hand, the referral to primary care was positive, while lacking the necessary emphasis to the importance of early postpartum review. Informing women to attend the UBS after the childbirth, in any way guarantee the understanding of the importance of home care they are entitled to, nor about all the available actions for the promotion and prevention of health problems arising from the execution of this care.

The guidelines failure at the hospital discharge about the importance of postpartum reviews and the lack of responsibility of health institutions with the patient who was discharged and went to the community, helps women take detrimental measures to their health in the home environment (Acosta, Gomes, Kerber, & Costa, 2012; Silva, Oliveira, Pinheiro, Ximenes, & Barroso, 2012).

The diagnosis of early postpartum review in the studied city indicated the disarticulation of the health service organization in the health care of women in immediate postpartum period, not yet consolidated. Thus, the EAPR offered to women in the MMLB while providing essential care to them, may be characterized as a barrier in the health service organization in the primary care level and tends to confuse women. The focus of the ward should fit the clinical and gynecological review inherent to hospital issues and the professionals' assignment would be making use of explanations of women's rights and duties of primary care in relation to postpartum reviews.

Early postpartum review in the household sphere proves to be an essential tool in postpartum that provides the relationship among the nurse, the woman and her family. This time the postpartum woman is free to express their doubts, feelings, complaints and questions, while the professional experiences their real conditions of life and creates strategies that strengthen protective factors of postpartum women and their families (Minasi, Barros, Souza, Pinheiro, Francioni, & Kerber, 2013).

It was found that the EAPR joining was superior to the implementation of HEPR in primary care. It is assumed that EAPR joining was higher, because it is a well structured service, with easy access and counting on disclosure by its professionals. On the other hand, HEPR had low offer, women's unawareness and it seems undervalued by professionals.

Primary care in the city is organized by the ESF and has 93 multiprofessional teams distributed in 52 UBS located in the urban and rural areas (Ministério da Saúde, 2015; Prefeitura Municipal, 2013). It is understood that there are human resources for the implementation of HEPR, yet this failed to materialize.

The fact of women's vulnerability in postpartum is not recognized as a health problem, in addition to professionals who view this period only on the biological level, and having no pathological basis, demand loses its meaning and importance and tends to be naturalized, disqualified and disregarded. On the other hand, the ESF runs into structural and organizational problems, having the need to prioritize the repressed demand to be met, focusing the assistance in the traditional biomedical model instead of health promotion which is based (Cabral, 2007).

The organization of health services in primary care is widely discussed, as well as its inconsistencies, traversing unreachable coefficients among goals, demands and human resources, being these essential for the implementation of the proposed actions. However, there is a really important point on which you cannot lose focus, the priority, the risk prevention, the extinction of the common sense perception that '*postpartum things*' are the mother's and their family's responsibility.

Other essential component to the HEPR performance is the success of the reference and referral system to primary care. Val (2012) pointed out that the reference / referral system is a programmatic obstacle to comprehensive care at different levels of complexity, as they are low or there is no feedback to UBS.

With regard to programmatic actions in postpartum period, those related to breastfeeding are directed to the incentive, breastfeeding maintenance and restoration, and especially prevention of early weaning. However, the offered services permeated between unsatisfactory, in the ambulation care and intermediate in house-hold care.

Britto (2012) demonstrated that educational actions aiming at encouraging breastfeeding in postpartum are essential to the humanization and quality of care and it is related to the organization of the health service, training and qualification of the professionals involved. Lima and Souza (2013) highlighted the home visit in postpartum as an important programmatic action to promote breastfeeding and to transpose the social vulnerability of women and the difficulties of access to health services.

In clinical-gynecological evaluation the triad of abdomen, surgical incision, episiotomy or perineum and lochia showed high and alarming rates between cares not offered to women in the EAPR and HEPR, as well as self-care guidelines for preventing and identifying possible complications. It is noteworthy that the postpartum women's lack of knowledge about the signs and symptoms of infection, bleeding and lack of information about the specific care of that period, make room to conducts based on beliefs and unfavorable attitudes.

Some complications from the immediate postpartum period can be attributed to lack of preparation and / or the professional misinformation and the woman's misunderstanding to the offered guidance, especially in hospital postpartum (Silva, Silva, Silva, Santos, Vilar, & Guimarães, 2012). Early postpartum review is an effective strategy for the diagnosis of characteristic postpartum situations, allowing nurses to carry out a plan of care or interventions that encourage self-awareness and encourage postpartum women to self-care (Riul, 2013).

Among the findings of this study, it was noted that in the EAPR the care extrapolated clinical aspects and addressed actions related to the psycho-emotional condition, creation of family relationship and planning, even without contextualizing and experiencing the woman's social reality. Despite the relevance of these actions in any service, it is believed that such information should be listed and discussed in the ESF domain, due to the understanding of the social context and the specific needs of postpartum women, made possible through home visits.

The ambulation care was found unsatisfactory in the evaluation of the newborn, but the referral to primary care and guidance offered to children exceeded the breastfeeding and self-care information, as well as the exclusive referral to the postpartum woman was too short, generating a welfare paradox.

In HEPR, many of the recommended programmatic actions were not carried out and breastfeeding was little spread as well as it was restricted to the clinical and gynecological evaluation of postpartum women who stayed at a lower level compared to physical examination and NB follow-up. It is stressed that the House-hold visit is a key piece in women's health and the professionals involved in this process, especially the nurse by the high number of visits observed in this

study, has the duty to approach the woman and her family, experiencing her reality, raising her complaints and conducting her, and going beyond the physiological postpartum aspect, observing the various roles she plays and not only the maternal one.

It is in this opportunity that the doors are open to the educational process, since the visit incorporates a set of knowledge and practices conducted for health promotion and disease prevention. It is imperative that nurses seek to understand the completeness of women, their ability to care and act as a facilitator in the postpartum period (Bernardi, Carraro, & Sebold, 2011).

By analyzing the programmatic actions within the triad organization of the health service, access and quality of service, the women's dropout in immediate postpartum period was evidenced. It can be inferred that the dropout situation occurred since the beginning of pregnancy and childbirth cycle, highlighted in the associations among the guidelines on delivery in prenatal care and the type of delivery with the dependent variable under study, *type of assistance in immediate postpartum period*, characterized in the absence of care and lack of accessible information for facing the immediate postpartum period. It continued in the hospital discharge, remaining, for some women in the ambulation and home care, as a result of scarce and inefficient actions in the immediate postpartum period and emerged alarmingly, for those mothers who have not had any type of care at this time.

To Monteiro (2011), the dropout in the immediate postpartum period begins in the hospital admission, where many women complain about the lack of the health professional support, especially to remedy their questions and address the insecurities and consistent barriers to their role as mothers. In the study by Rodrigues, Fernandes Silva and Rodrigues (2006), they found the abandonment suffered by women in the immediate postpartum period, as evidenced by reports regarding the failure in prenatal care, hospitalization, under the relevant guidelines to the postpartum period, as well as its unpreparedness to experience it, and the non execution of the Home visit, right time to answer questions and promote the binomial health.

Even with the problems discussed here, the women were satisfied with the care offered in the EAPR, unlike when asked about their satisfaction with the HEPR. The dissatisfaction with early postpartum review in the home environment, it was probably due to the low number of practiced visits and lack of relationship with the UBS's professionals. To Álvarez-Franco (2013), the satisfaction of postpartum women is linked to the professional who assists them and the way the professional offers comfort and well-being, physically and emotionally, to them, their child and family.

It is concluded that the action analysis offered to women in immediate postpartum period in this study brought up elements of the programmatic vulnerability as the fragmentation of the health service organization, the barriers to access and low care quality. This diagnosis refers to the need to revisit the actions implemented in the municipality, through meetings in primary care environment between postpartum ward of the MMLB and the FHS's municipal managers to define the actions to be performed by each service, the qualification of professionals involved and follow-up of a single protocol, thus preventing that the assistance does not generate unnecessary costs due to duplication of some actions, lack of others and does not compromise the women's health, materialized in the fragmentation of care, the weaknesses of completeness and humanization of care, nowadays.

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Figure 1 – Flowchart showing the monitoring of women in immediate postpartum period in Londrina (PR).

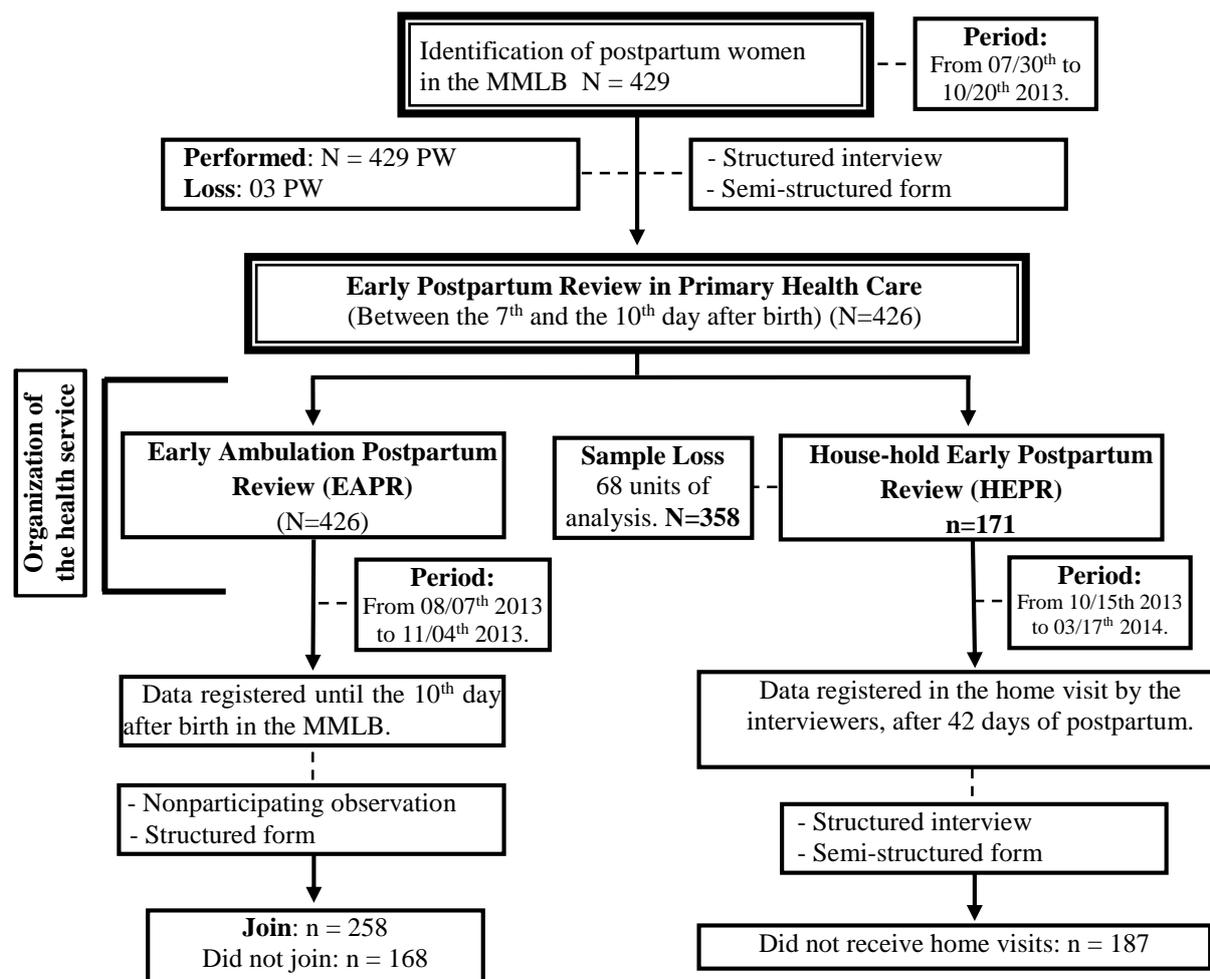


Table 1: Distribution of women according to the type of care received in immediate postpartum period. Londrina (PR), 2014.

Type of assistance in immediate postpartum period	n	%
EAPR* and HEPR**	101	28.2
EAPR	122	34.1
HEPR	70	19.5
None	65	18.2
<b>Total</b>	<b>358</b>	<b>100.0</b>

\*EAPR: Early Ambulation Postpartum Review.

\*\*HEPR: House-hold Early Postpartum Review.

Table 2: Distribution of services offered in the early ambulation and house-hold postpartum review, according to the programmatic actions proposed by the Municipality and Ministry of Health. Londrina (PR), 2014.

Care to be offered in immediate postpartum		Early Ambulation Postpartum Review (N=426) n = 258				House-hold Early Postpartum Review (N=358) n = 171				Both attendances (N=358) n = 101									
		Yes		No		Yes		No		EAPR*				HEPR**					
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%		
Women	Anamnesis	Postpartum booklet checking	-	-	258	100.0	-	-	171	100.0	-	-	101	100.0	-	-	101	100.0	
		Use of medications	258	100.0	-	-	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0	
		Sleep and rest	258	100.0	-	-	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0	
		Psycho-emotional condition	258	100.0	-	-	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0	
		Mother and son relationship	258	100.0	-	-	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0	
		Breastfeeding difficulties	15	5.8	243	94.2	-	-	171	100.0	08	7.9	93	92.1	-	-	101	100.0	
		Current NB breastfeeding	258	100.0	-	-	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0	
		Early weaning risk	258	100.0	-	-	-	-	171	100.0	17	16.8	84	83.2	-	-	101	100.0	
		Hygiene conditions	255	98.8	03	1.2	-	-	171	100.0	98	97.9	03	3.0	-	-	101	100.0	
		Clinical and gynecological evaluation	Vital signs checking	256	99.2	02	0.8	-	-	171	100.0	101	100.0	-	-	-	-	101	100.0
			Breastfeeding evaluation	14	5.4	244	94.6	86	50.3	85	49.7	05	5.0	96	95.0	52	51.5	49	48.5
			Breast conditions	234	90.7	24	9.3	104	60.8	67	39.2	89	88.1	12	11.9	61	60.4	40	39.6
			Observation of Abdomen	189	73.2	69	26.8	80	46.8	91	53.2	72	71.3	29	28.7	50	49.5	51	50.5
			Aspect of surgical incision / episiotomy / perineum	212	82.2	46	17.8	55	32.2	116	67.8	82	81.2	19	18.8	33	32.7	68	67.3
			Lochia	157	60.9	101	39.1	55	32.2	116	67.8	59	58.2	42	41.6	34	33.7	67	66.3
			Urinary habits	254	98.5	04	1.5	-	-	171	100.0	100	99.0	01	1.0	-	-	101	100.0
			Bowel habits	255	98.8	03	1.2	-	-	171	100.0	89	88.1	12	11.9	-	-	101	100.0
		Guidelines	Breastfeeding	90	34.9	168	65.1	86	50.3	85	49.7	35	34.7	66	65.3	52	51.5	49	48.5
			Self-care	60	23.2	198	76.7	-	-	171	100.0	20	19.8	81	80.2	-	-	101	100.0
			Family planning	246	95.3	12	4.7	-	-	171	100.0	99	98	02	2.0	-	-	101	100.0
		Follow-up	Schedule of late postpartum review	-	-	258	100.0	79	46.2	92	53.8	-	-	101	100.0	35	34.7	66	65.3
NB***	Anamnesis	Child's health booklet	258	100.0	-	-	131	76.6	40	23.4	101	100.0	-	-	78	77.2	23	22.8	
		Weight	-	-	258	100.0	33	19.3	138	80.7	-	-	101	100.0	22	21.8	79	78.2	
		Physical examination	-	-	258	100.0	88	51.5	83	48.5	-	-	101	100.0	54	53.5	47	46.5	
		Guidelines	NB's care	230	89.1	28	10.9	131	76.6	40	23.4	91	90.1	10	9.9	78	77.2	23	22.8
			Childcare and vaccines	215	83.3	43	16.7	131	76.6	40	23.4	83	82.2	18	17.8	78	77.2	23	22.8

\*EAPR: Early Ambulation Postpartum Review.

\*\*HEPR: House-hold Early Postpartum Review.

\*\*\*NB: Newborn.

Table 3: Relationship between type of assistance in immediate postpartum and the variables of obstetric history. Londrina (PR), 2014. N = 358.

Variables	Type of attendance in immediate postpartum								Value of p*
	Ward and house-hold (n=101)		Just ward (n=122)		Just house-hold (n=70)		None (n=65)		
	n	%	n	%	n	%	n	%	
<b>Parity</b>									
Primiparous	40	39.6	52	42.6	27	38.6	24	36.9	0.645
Multiparous	61	60.4	70	57.4	43	61.4	41	63.1	
<b>Prenatal Adequacy</b>									
Adequate	23	22.8	37	30.3	13	18.6	18	27.7	0.613
Intermediate	49	48.5	57	46.7	39	55.7	24	36.9	
Inadequate	29	28.7	28	23.0	18	25.7	23	35.4	
<b>Guidelines in prenatal</b>									
<b>Type of birth</b>									
Yes	30	29.7	23	18.9	14	20.0	11	16.9	0.061
No	71	70.3	99	81.1	56	80.0	54	83.1	
<b>Signs of labor</b>									
Yes	32	31.7	29	23.8	23	32.9	17	26.2	0.746
No	69	68.3	93	76.2	47	67.1	48	73.8	
<b>Birth</b>									
Yes	60	59.4	53	43.4	35	50.0	26	40.0	0.036
No	41	40.6	69	56.6	35	50.0	39	60.0	
<b>Interval between prenatal and birth</b>									
0 to 15 days	72	71.3	94	77.0	48	68.6	46	70.8	0.790
16 to 30 days	21	20.8	17	13.9	16	22.9	13	20.0	
31 and + days	08	7.9	11	9.0	06	8.5	06	9.3	
<b>Type of birth</b>									
ND** spontaneous	69	68.3	79	64.8	55	78.6	57	87.7	0.002
ND instrumental	01	1.0	05	4.1	01	1.4	-	-	
Cesarean	31	30.7	38	31.1	14	20.0	08	12.3	
<b>Induction of labor</b>									
Yes	35	34.7	61	50.0	26	37.1	31	47.7	0.914
No	66	65.3	61	50.0	44	62.9	34	52.3	
<b>Intrapartum complications</b>									
Yes	34	33.7	44	6.1	17	24.3	17	26.2	0.134
No	67	66.3	78	63.9	53	75.7	48	73.8	
<b>Perineum conditions</b>									
Intact	58	57.5	66	54.1	47	67.1	37	56.9	0.751
First-degree tear	28	27.7	27	22.1	07	10.0	16	24.6	
Second-degree tear	08	7.9	11	9.0	08	11.4	06	9.2	
Episiotomy	07	6.9	18	14.7	08	11.4	06	9.2	
<b>Discharge guidelines</b>									
<b>Postpartum infection</b>									
Yes	26	25,7	31	25.4	13	18.6	14	21.5	0.334
No	75	74,3	91	74.6	57	81.4	51	78.5	
<b>Bleeding</b>									
Yes	15	14,9	17	13.9	08	11.4	12	18.5	0.712
No	86	85,1	105	86.1	62	88.6	53	81.5	
<b>Reference location for BF***</b>									
Yes	52	51,5	68	55.7	31	44.3	36	55.4	0.943
No	49	48,5	54	44.3	39	55.7	29	44.6	
<b>Referral</b>									
Yes	88	87,1	99	81.1	62	88.6	52	80.0	0.477
No	13	12,9	23	18.9	08	11.4	13	20.0	

\*Chi-square test  $p \leq 0.05$ .

\*\*ND: Normal Delivery.

\*\*\*BF: Breastfeeding.