

Reproductive planning and vulnerability after childbirth: a cohort from southern Brazil *

Planejamento reprodutivo e a vulnerabilidade após o parto: uma coorte do sul do Brasil

Planeamiento reproductivo y la vulnerabilidad tras el parto: una cohorte del sur de Brasil

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Abstract: Objective: it is to analyze the reproductive planning in the first year after the childbirth in women that keeps the healthy accompaniment in the primary and secondary attention. **Method:** it deals with a prospective cohort, which it was conducted with 300 women, in big towns of Parana State, Brazil, from July of 2013 to March of 2015. It was data used analysis through Qui- square tests. **Results:** it was verified association between contraceptive use, conjugal situation and earned income. The children's birth and Cesarean also are associated to the contraceptives usage. It was ascertained a statistics relevancy among the planned pregnancy with a woman being pregnant again. There was association between the registration in the health caring program and reproductive planning program, hormonal methods used in the health care access. It occurred a significantly statistics between the premature puerperal laboratory and inscription at the reproductive planning. **Conclusion:** it was verified the restriction in the implementation of sexual and reproductive health policies after the childbirth.

Descriptors: Contraception; Primary health care; Family; Postpartum period; Sexual health, Program evaluation

Resumo: Objetivo: analisar o planejamento reprodutivo no primeiro ano após o parto em mulheres que mantêm seguimento/acompanhamento em saúde na atenção primária e secundária. **Método:** trata-se de uma coorte

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prospectiva, conduzida com 300 mulheres, em município de grande porte do estado do Paraná, Brasil, entre julho de 2013 a março de 2015. Utilizou-se análise dos dados por meio do Teste Qui-quadrado. **Resultados:** foi verificada associação entre o uso de contraceptivo, situação conjugal e renda. A paridade e cesárea anterior também se associaram ao uso de contraceptivos. Verificou-se relevância estatística entre a gravidez planejada e estar grávida novamente. Houve associação entre inscrição no programa de planejamento reprodutivo e uso de contraceptivo, uso de método hormonal e acesso ao serviço de saúde. Ocorreu significância estatística entre a realização da revisão puerperal precoce ambulatorial e inscrição no planejamento reprodutivo. **Conclusão:** constatou-se restrição na aplicação das políticas de saúde sexual e reprodutiva após o parto.

Descritores: Anticoncepção; Atenção primária à saúde; Período pós-parto; Saúde sexual; Avaliação de programas e projetos de saúde

Resumen: Objetivo: evaluar el planeamiento reproductivo en el primer año tras el parto en mujeres que mantienen seguimiento/acompañamiento en salud en la atención básica y secundaria. **Método:** se trata de una cohorte prospectiva, que se realizó con 300 mujeres, en un gran municipio del estado de Paraná, Brasil, entre julio de 2013 y marzo de 2015. Se utilizó análisis de datos por medio de la Prueba Chi cuadrada. **Resultados:** se verificó asociación entre el uso de anticonceptivo, situación conyugal y renta. La paridad y cesárea anterior también se relacionaron al uso de anticonceptivos. Se constató relevancia estadística entre la gravidez planeada y estar embarazada nuevamente. Hubo asociación entre inscripción en el programa de planeamiento reproductivo y uso de anticonceptivo, uso de método hormonal y acceso al servicio de salud. Ocurrió significancia estadística entre realización de la revisión puerperal precoz en ambulatorio e inscripción en el planeamiento reproductivo. **Conclusión:** se constató restricción en la aplicación de las políticas de salud sexual y reproductiva tras el parto.

Descriptor: Anticoncepción; Atención primaria de salud; Periodo posparto; Salud sexual; Evaluación de programas y proyectos de salud

Introduction

The post childbirth period is a moment when women present changes and physical adaptation, emotional and social, they look for the return to the earlier pregnancy condition. Among the adaptation that women go through there is the sexual practice come return.¹

The helping out to the reproductive health is defined as methods conjunct, techniques, input and services that it contributes to health and reproductive welfare, it will prevent and solve reproductive health problems. Therefore, since 2011, the assistance was installed to fulfill the system searching, it is intended to face the fragile access to the reproductive planning services.² The actions of reproductive planning are developed, mainly, by Primary Attention to Health (APS), the puerperal appointment is a convenient moment to orientation and encouragement to this practice.³ The access to the contraception is essential to promote women

health and autonomy; a cohort study in “Rio Grande do Sul” has verified that 24,8% of them haven’t realized puerperal appointment.⁴

This way, the reproductive planning comprises the health and safe sexual promotion, the fecundity regulation if the couple wants it and preparation for a responsible paternity.⁵ In Brazil, the health service installment at the post childbirth has not been realized in an appropriate way, it has been associated to the low assistance quality, few infrastructure and devaluation in this period.⁶

It is convenient to detach that the fifth goal of the sustainable development is: “reach the genre equality and empower all women and girls”. Among the actions programmed to this goal there is “To Ensure Universal Access to Sexual and Reproductive Health and Reproductive Rights of Women in Compliance with the Action Program from the International Conference about Population and Development and the Beijing Platform for Action and the documents that resulted from its review conferences”.⁷ Therefore, in the last decades the theme about reproductive health has been increasing in the scientific community, its approaching goes beyond the biological element, it has been appreciating ethics areas, policy and social.

The literature demonstrates that that negative maternal and neonatal health outcomes in developing countries could be prevented with proper reproductive planning.⁸ For this reason, this study aims to analyze the reproductive planning in the first year after the childbirth in women that keep continuity/ accompaniment in health in the primary and secondary attention.

Method

It is about a prospective cohort conducted with women in their post childbirth, who live in big cities of Parana State, Brazil, they are followed in attention levels to the primary and secondary health. The sample was calculated based on 3,415 births in 2012, with 358 women. There were included puerperal women of habitual or intermediate obstetric risk, they were hospitalized in this maternity hospital who lived in the urban area and who participated in the

four stages of the immediate puerperium research, Early Ambulatory Puerperal Review (RPPA), Late Puerperal Review (RPT), Remote Puerperal Review (RPR); puerperal women with a high-risk diagnosis were excluded. The end of the study was with 300 women. Data collection took place from July 2013 to March 2015, in four sequential phases.

The first phase started with the daily identification of women in the joint accommodation unit in a public maternity of habitual and intermediate risk, to obtain data from the Pregnant Woman's Card, medical record and interview. In the second, it was proceed the observation to the non participating woman of the RPPA Review in the maternity (immediate puerperium, 7th to 10th day after childbirth). In the third, RPT (late puerperium, 42nd day after the childbirth), and in the fourth phase, 2xRPR (remote puerperium, one year after the childbirth), it was realized home visit.

In 2011, the maternity hospital started the puerperium ambulatory service, at first to reduce infection cases in the post childbirth period, readmission rates, the maternal mortality rate and to maintain a feedback on the care provided. Furthermore, it provides information about the breast-feeding maternal and reproductive planning. The clinic attends from Monday to Friday since eight a.m. until one p.m., only puerperal woman whose childbirth was realized in the institution. About 12 women go per day for RPPA (1st to 10th after childbirth). The team consists of a gynecologist, an obstetrical nurse and a nursing technician.⁹

RPPA is performed daily by a nurse with medical evaluation aid three days a week. On other days, if it is necessary, the evaluation is carried out by the doctor on duty. The clinic has a scheduling service, below the responsibility of the nursing technician. A reminder of its schedule is attached daily to the child's card, twenty-four hours before the dyad's hospital discharge. If there is the permanence of the newborn at the institution, puerperal woman will not lose her rights about the ambulatory service. For women who are absent at the scheduled review day, there is the possibility of keep in touch with the maternity to set a new date, though it must be done no later than seven days. The ambulatory does not realize active search of the

puerperal women, due this action extrapolates the period recommended by the institution (immediate puerperium), however, there is a counter-reference of all puerperal women for primary care at the time of hospital discharge.⁹

The city's PHC is organized through the Family Health Strategy (FHS), which is divided into 6 regions with 54 Basic Health Units (UBS): 42 in the urban area and 12 in the rural area. In addition to the family health teams, the UBSs in the urban area have 10 teams from the Family Health Support Center (NASF), that was established in 2008, it is consisted by professionals from different health areas (nutrition, physiotherapy, pharmacy, physical education, psychology), who work with the FHS in their respective territories.⁹

The actions for health promotion, disease prevention and home visit are common to all members of ESF and NASF. The nurse, in addition to other duties, has a specific performance in prenatal and postpartum appointment at the BHU. Since the beginning of the prenatal, the pregnant medical record is separated and it starts to be considered an assistance priority. After childbirth, the responsible worker for technical-administrative actions at UBS verifies the child's birth, through the internal system between the maternity hospital and the UBS, and he/ she communicates the responsible nurse for the coverage area where postpartum woman lives. The nurse schedules the RPP (between the 7th and 10th postpartum day) performed during the home visit. In this service, the TPR is scheduled (between 30th and 42nd postpartum days) to be performed at the BHU. In the user's return to the UBS, RPR is scheduled (between 43rd and 365th postpartum day).⁹

Reproductive Planning service is available to all city population, with fertile age, who seek assistance with Reproductive Planning or who are professionally directed to this purpose, it is preserved knowledge about the sexual and reproductive rights of men, women and couples. Temporary methods are available in all Health Units: oral and injectable contraceptives (monthly and quarterly) and preservatives (male and female condom); Intrauterine Device (IUD) it is available

in some Units and at Municipal Matricial support Unit and Teaching in Family Health (UMMESF). For surgical methods (tubal ligation and vasectomy), the city has references from the Intermunicipal Health Consortium of the Middle Paranapanema (CISMEPAR) and City Maternity.⁹

It was used in the data collecting instrument objective questions, it was asked questions as: social demographics, reproductive planning (planned pregnancy, being pregnant again, it was signed up at the familiar planning program, with contraceptive use, where it was offered), puerperal review (puerperal woman came back to the puerperal review, and those who realized the appointment, guidelines during the puerperal appointment, counter reference, the person received home visit (HV) of a UBS professional after childbirth, until the 7th day after the childbirth, because she looked for the UBS after childbirth, the professional who did it late, he/she scheduled the remote puerperal review (after 43rd postpartum day) in the UBS by professional who had scheduled the remote puerperal review at the UBS.

After adjustments, the collection was previously tested and it was started until it could reach the number sample. I It was used the Statistical Package for Social Sciences (SPSS) program, 20.0 version, it was used for statistical analysis whereby the Chi-square test with a 5% significance level, to verify possible associations ($p \leq 0.05$) with the dependent variables: “Contraceptive method usage” and “registration in the reproductive planning program”. The selected independent variables included social and demographic aspects, obstetric history and reproductive planning.

In compliance with the Resolution 466/12, from the National Health Council, the Research Ethics Committee Involving Human Beings, under the CAAEE approval protocol 193525139.9.0000.5231, it approved the research project on July 16th, 2013. After the approval, the institution was notified to start collecting data from medical recording and before the interview with women/users. All participants were informed about the research goals, they had the

anonymity guarantee and the right to participate or not, they had the entitlement to express their consent by signing the Informed Consent Form.

Results

The study sample was characterized by young women between 20-34 years of old 69.6% (209), with a partner 85.6% (257), earned income of up to one minimum salary 69.6% (209), the majority women don't have a remunerate income 59.6% (179).

There was a statistical difference between the conjugal status and the use of contraceptive method (CM) ($p < 0.001$) between the 7th and 42nd days after childbirth. The highest proportion of women who had a partner used contraceptives when compared to single women. The use of CM was also significantly associated with income in the late puerperium: those with lower income made less use of contraception. When a woman is pregnant, it was found out that the majority of unpaid women did not use CM. The use of contraception was more regular among multipara women than primiparous women.

Most women with natural childbirth did not use contraception. In the approach to reproductive planning, it was identified that there was statistical significance between the planned pregnancy and the use of CM when it was intended to become pregnant. Most couples who did not want to become pregnant were using contraceptives.

Being pregnant again was associated with the use of CM in the remote puerperium, which only 40% of women used contraceptives. The use of CM was also significantly associated with the reason that woman was not enrolled in the reproductive planning program (PPR) in the late puerperium (Chart 1).

Chart 1 – Contraceptive usage method. Londrina, PR, 2019

Independent Variables	When getting pregnant			7 th – 42 nd postpartum day			1 st year after childbirth		
	Yes		Value of p	Yes		Value of p	Yes		Value of p
	n	(%)		n	(%)		n	(%)	
Conjugal situation									
With partner	86	84.3		225	90.4		229	87.1	
Without partner	16	15.7	0.728	24	9.6	<0.001	34	12.9	0.078
Income									
≤1 Minimum Salary	68	66.7		167	67.1		181	68.8	
≥3 Minimum Salary	34	33.3	0.556	82	32.9	0.034	82	31.2	0.504
Profession									
Remunerated	51	50.0		103	41.4		109	41.4	
Not remunerated	51	50.0	0.018	146	58.6	0.439	154	58.6	0.372
Parity									
Primiparous woman	31	30.4		90	36.1		97	36.9	
Multipara woman	71	69.6	0.046	159	63.9	0.113	166	63.1	0.206
Kind of childbirth									
Natural	76	74.5		182	73.1		191	72.6	
Cesarean	26	25.5	0.96	67	26.9	0.379	72	27.4	0.055
Planned pregnancy									
The couple wanted	43	42.2		155	62.2		158	60.1	
The couple did not want	59	57.8	<0.001	94	37.8	0.158	105	39.9	0.859
Pregnant again*									
Yes	–	–		1	52.2		6	40.0	<0.001

* 15 women get pregnant in the postpartum period during the study

Chart 2 shows that registration in the PPR and the CM use showed a positive association in the early, late and remote puerperium, it demonstrated that the highest proportion of women registered in the program used contraceptives. Likewise, there was an association between enrollment in the PPR and the use of hormonal methods in the early, late and remote puerperium. The oral contraceptive was predominant in the health service in the early, late and remote puerperium.

In the puerperal review accompaniment, there was a statistical difference between scheduling at RPPA PPR registration, to the detriment of schedules at RPT and RPR. The

highest proportion of women who did not have a puerperal appointment was also not registered in PPR.

Most women did not know the existence of the puerperal review service. Among the users who performed the puerperal appointment, guidelines for childcare predominated.

Chart 2 – Reproductive planning practice. Londrina, PR, 2019

Reproductive Planning	10 th postpartum day		Value of p	42 nd postpartum day		Value of p	1 st postpartum year		Value of p
	Yes			Yes			Yes		
	n	(%)	n	(%)	n	(%)			
Contraceptive method usage									
Yes	161	89.0	0.001	98	96.1	<0.001	53	94	0.001
No	20	11.0		4	3.9		10	6.1	
Contraceptive Method usage									
Barrier	33	20.9	0.021	7	7.1	<0.001	11	7.2	0.003
Hormonal	117	70.9		78	74.5		109	27	
Surgical	13	8.2		18	18.4		33	21	
Offer place									
Health service	164	85.1	p≤0.001	92	90.2	<0.001	127	83	<0.001
Pharmacy (shopping)	26	14.4	1	7	6.9		26	17	
It was not given	1	0.6		3	2.9		–	–	
RP schedule*									
Yes	27	33.3	0.002	27	49.1	0.488	59	36	0.394
No	54	66.7		28	50.9		104	64	

*Puerperal Review

Chart 3 presents data regarding to the follow-up of the puerperal woman in the puerperal review clinic and in the PHC, it was showed statistical significance between the performance of the RPPA on the seventh day after childbirth and registration in the reproductive planning. Most women who performed on the seventh day after childbirth were registered in PPR. In the RPP on the tenth day after childbirth, majority who were registered in the PPR were attended by a nurse.

Chart 3 – Puerperal women monitoring by the health service. Londrina, PR, 2019

Health Service	7 th postpartum day			10 th postpartum day			1 st postpartum year		
	Yes		Value of p	Yes		Value of p	Yes		Value of p
	n	(%)		n	(%)		n	(%)	
Puerperal Review									
Yes	55	39.3	0.087	181	96.3	<0.0001	59	57.8	0.39
No	47	29.4		–	–		104	52.5	
Professional									
Doctor	–	–	0.026	16	88.9	0.136	32	56.1	0.84
Nurse	37	48.7		165	97.1		27	60	
CHA*	5	20		–	–		–	–	

*Community Health Agent

There was an association, in the late and remote puerperium, between the service looking for reproductive planning and registration in the PPR. The biggest proportion of women who did not look for the service for reproductive planning in the late puerperium, they were also not registered in the PPR. However, one year after childbirth, those who looked about the service for reproductive planning were signed up in the PPR. (Chart 4)

Chart 4 – Reproductive planning practice after the childbirth . Londrina-PR, 2019

Reproductive Planning Practice	42 nd postpartum day					1 st year after childbirth				
	Yes		No		Value of p	Yes		No		Value of p
	n	(%)	n	(%)		n	(%)	n	(%)	
Who looked for the service										
Yes	30	63	18	37.5		102	93.6	7	6.4	
No	72	29	180	71.4	<0.001	61	31.9	130	68.1	<0.001
Gynecologist										
Yes	42	31	92	68.7		83	54.6	69	45.4	
No	60	36	106	63.9	0.394	80	54.1	68	45.9	1.000

Discussion

The family planning concept is in the Federal Constitution and it is regulated by Law N. 9.263 / 96, which includes family planning as a set of actions to regulate fertility, in order that to guarantee equal rights, limitation or increase of offspring by women, by man or couple.²

Considering the expansion of the term "family planning", it is attempt to replace it by "reproductive planning", because it can be carried out independently of the family institution. It is established on the assumption of free and informed decision, human dignity and responsible paternity, which State is responsible to provide resources for action and this norm maintenance.¹⁰

The profile found in this study, of adults and adolescents women, corroborates with the data in the literature, which identifies this as the population that gets pregnant most in Brazil.¹¹ This evidence warms up the discussions about the risks to which these young women are exposed to, such as low weight of the newborn, premature childbirth, surgical childbirth associated with sterilization as a measure of reproductive planning and successive pregnancies with an interval of less than two years.¹²

Another question is eligibility for benefits regarding of this population, because the increase in the sexual quality in reproductive health influences directly the reduction of poverty and the improvement of the living conditions of individuals.¹¹ It was found out that, in the late puerperium, women with less living condition did not practice contraception method. Individuals with a lower income have more needs and dissatisfaction with contraception. A study carried out in the Middle East region of Ghana has identified an increase in the use of contraception according to parity, to limit the number of pregnancies.¹³ The literature shows in what way reproductive planning is developed in public health does not cover the core family potential, since there is no information on how to relate income with the children number, or with each family member education and health investments.⁶

Reproductive life planning consists of including what the individual or couple expects for their future in relation to education, occupation and relationships. Female reports about contraceptive use are associated with financial aspects, job and education.¹⁴

Contraception and a partner existence proved to be influential throughout the study period, with adherence to contraceptive methods most by women who lived with partners.

However, there was a trend towards the use of hormonal methods when it compared to the use of barrier methods by this population. Few women used preservatives, so that they were vulnerable to sexually transmissible infections. In a qualitative research on reproduction, contraceptive practices and voluntary abortion, it was found that, as there was stability in relationships, couples were dispensing preservatives use, and they were subjugated to risks.¹⁵

Autonomy over fertility is seen as one of the hawser of the female empowerment process, therefore, the consequences of an unplanned pregnancy is up to women. Thus, this solitary search for contraception is understood as natural.¹⁶ The lack of planning or desire for pregnancy among couples in this study was considered relevant. These data show an inability or difficulties in contraceptive methods usage, since a significant number of women used contraception when they became pregnant.

Unplanned pregnancies are considered to be whatever and all pregnancies that were not programmed by parents, and may occur in an unwanted manner, when they are opposite to their expectations, or inopportune, when they occur in an unfavorable period.¹⁵ Unplanned pregnancy should be considered a public health problem. It is estimated that every year 80 million women in the world conceive an unplanned pregnancy, and 60% of them abort which makes worse perinatal morbidity and mortality rates.¹⁶

Regardless none contraceptive methods evolution over time, as well as access to information and health services, no contraceptive can be considered ideal, due to its technical and biological limitations, however, its biggest obstacle is the cultural barrier crossing.¹⁷ This way, this phenomenon occurs in the present study. Women with children looked more often for the reproductive planning and contraceptive use service. However, the literature shows that this search occurs not to plan the desired number of children or to have an adequate interval between pregnancies, but to stop fertility.⁶

Likewise, in this study, women who were submitted to previous cesarean section did not practice contraception, they were more likely to sterilization as a contraceptive method. In

contexts with social inequality emphasized, sexuality experience is often restricted to the biological conception, and it is disconnected from sexual delight. Again, these women have less control over their body, their reproductive capacity and fertility, once again the search for measures to control their offspring through by sterilization.¹⁸

Although there is a positive influence on the contraceptives usage, public health service was limited to offer hormonal methods offering. These are the most used worldwide, as they are reversible, efficient and available. However, due to its daily intake, it is necessary a prolonged use, what makes its use more forgettable, which increases its failure rate. There is also a direct relation between the low socioeconomic status and the prevalence of pill consumption.¹⁹

According to the worldwide family planning survey, in 2013, 63% of married women, aged 15 to 49 years, used some method for reproductive planning. These 57% used methods are considered modern, what include pills, IUDs, injection, preservatives and sterilization.²⁰

In the first year after childbirth, such characteristics were found in the studied population: women with a partner, there were a higher concentration of hormonal methods and prevalence of low income. Therefore, for this group of women to exercise their free and informed choice of contraception, it is necessary to expand access to other types of contraceptives, empower their body's self-knowledge and pay attention to women vulnerability with lower income.⁷

Assistance to sexual and reproductive health has been one of the priority areas of primary care, with the principle of guaranteeing sexual and reproductive rights, which is based on the National Policy for Integral Assistance to Women's Health and the National Policy on Sexual and Reproductive Rights.²¹ Therefore, PHC should be prepared to develop three main activities in reproductive health area: advising, education and clinic. However, the actions are limited to contraceptives offer and distribution, with an emphasis on the pregnancy-puerperal cycle, it diverts its focus from women who do not have a gestational history, who are not sexually active, or even suffer from infertility.⁶

Puerperal appointment is one of the PHC care strategies, especially in the first week after childbirth, because it allows the construction of connection with the user, it provides hospitality and it promotes preventive, holistic and resolution care of problems that may happen. However, the actions provided in this period are deficient in directions related to the integral woman care, which the focus is the newborn assistance. Therefore, the appointment carried out at this time does not guarantee the necessary self-confidence for puerperal woman to perform self-care with excellence.²²

In the study, it was verified that the search for care by the user was relevant, because the search for the reproductive planning service in the remote puerperium resulted in the inclusion of women in this program. It is highlighted, however, that several puerperal women looked for and they were attended by the gynecology service, but they were not included in the PPR, what reaffirms the care fragmentation and a restricted look at the woman who is in the postpartum period.

This diagnosis is unfavorable to the health care proposal in primary care and it demonstrates that specialized care is still centered in the doctor figure, to the detriment of multiprofessionality. Nursing, by turn, lost or ceased to occupy a space that is guaranteed to it, to carry out appointments in the reproductive planning monitoring and prescription of care and treatment, through protocols establishment.²³⁻²⁴ Toward this fact, it was found that secondary care played a crucial role in the women inclusion in the RPP, what becomes another alternative to fulfill the PHC needs.

The role of the nurse was fundamental for the women rescue, in the first days after childbirth, and their insertion in the PPR, what confirm their effective participation in the early puerperium and action in the primary and secondary health network. The health worker is seen as an agent of power by the user, and it is through effective health practices that she will be strengthened to make adequate contraceptive choices and their practice.²⁵

Evasion of women over time was also observed, as they stopped to use contraceptive methods offered at public service and started to obtain them at the private sector. This situation refers to the precarious uptake of mothers during the first year, with a significant decrease in the performance of the remote and late puerperal review compared to the early one. A study carried out with puerperal women in Minas Gerais found a similar situation, which 40.2% of the puerperal women intended to obtain the method chosen in pharmacies.²⁶

Gaps left by public service in Brazil in relation to reproductive health care denotes the restriction in the contraceptives distribution, little team involvement a low female adherence to the proposed activities. It is detached that these factors are worse when the health service disregards gender influence in the female experience with contraception.²⁷

The weakness of the reproductive planning monitoring by the public health service was reinforced when there was pregnancy recurrence in some women in the late and remote puerperium, what confirms the risk of premature births in short pregnancies lapse.

The main reason reported for woman do not use contraceptives was the option of not avoiding a new pregnancy. This situation raises aspects that involve gender relations, beliefs and attitude in health and, in this paradigm, the conception of the female, cultural and social constructed role, however it is based on reproductive capacity.

Motherhood is seen culturally as something inherent to women, instinctive response. The ability to gestate is also historically attributed as a feminine value within the family.²⁸ It is believed that, in the Brazilian social context, the pregnancy occurrence is not enough to incite adherence to reproductive planning, which it only occurs significantly after consecutive pregnancy repetition. Since that a desperate search for birth control takes place.²⁹

Pregnancy is due to the relationship between man and woman, so, it is expected that contraception is a both decision, equally with they both involved in this process. However, many women find themselves in a context of little or no partner participation, and the search for

contraception is a solitary journey. In this way, the health service must organize itself to promote a reproductive planning program that enables respect for the women autonomy, what it is translated by the rescue of integral care for the female body, her biological, emotional and social character, and for the responsible parenthood exercise.

Itinerant women profile that was covered in the research resulted in the data difficulty collecting for the third and fourth study stages, what reduces the sample throughout the first year after childbirth.

Conclusion

User continuity, in the first year after childbirth period demonstrated that puerperal ambulatory appointment performed in the secondary service and early puerperal appointment realized in primary care were positive for woman's enrollment in reproductive planning, with nurses' predominance to happen the appointment realization. However, the identified fragility, such as accompaniment discontinuity in the review at the remote puerperium, assistance and guidance mainly directed to child health, in addition the low women registration in the PPR throughout the first year after childbirth period, whwn they were starkly influential in the their non-adherence to reproductive care through contraceptives using.

Despite the postpartum being a feminine vulnerability period, it was found, in the study, restriction in sexual and reproductive health policies application and the main activity is the supply and distribution of hormonal contraceptives. The rescue and application of reproductive planning concept is emerging, since the search in this period requires effective actions by the health service and commitment of health workers.

Through this study, it is possible to reaffirm the women vulnerability when it is after childbirth, considered reproductive aspects. This is a population in which politics strategies and health programs, such as postpartum care, what includes puerperal review with guidance on

reproductive planning, it does not produce the appropriate result. So, it is clear that the nurse performance, when it is properly performed, he/ she is able to transform a social reality and to allow the user access to what is her right, with information, prevention and service provision.

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