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# Care model for pregnant and puerperal women: a perspective of family health professionals

Modelo de cuidado a gestantes e puérperas: perspectiva de profissionais da saúde da família

Modelo de atención a la gestante y puerperal: la perspectiva de los profesionales de la salud de la familia

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**Abstract**: **Objective**: To understand the model that guides the care of pregnant and puerperal women in the Family Health Strategy. **Method**: This is a qualitative study. Eight health professionals from a Family Health Strategy team participated in the semi-structured interviews between March and April 2019, in the state of Rio Grande do Sul, Brazil. The data were analyzed according to thematic content analysis. **Results**: The model of care for pregnant and puerperal women in Primary Health Care developed by health professionals is incipient and predominant in the biomedical model, as it does not consider the integrality, coordination, and longitudinal care. **Conclusion**: investments in permanent and continuous education of health professionals are needed so that they act in favor of the model proposed by the Primary Care, based on humanization and bonding relationships, and ensure comprehensive care to pregnant and puerperal women.
**Descriptors:** Nursing; Primary Health Care; Maternal and child health; Prenatal care; Health personnel

**Resumo:** **Objetivo:** compreender o modelo que orienta o cuidado à gestante e à puérpera na Estratégia Saúde da Família. **Método:** estudo qualitativo. Participaram das entrevistas semiestruturadas oito profissionais da saúde de uma equipe de uma Estratégia Saúde da Família, entre março e abril de 2019, no Estado do Rio Grande do Sul, Brasil. Os dados foram analisados conforme análise de conteúdo temática. **Resultados:** o modelo de cuidado à gestante e à puérpera na Atenção Primária à Saúde desenvolvido pelos profissionais da saúde mostra-se incipiente e com predomínio no modelo biomédico, pois não considera a

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integralidade, a coordenação e a longitudinalidade do cuidado. **Conclusão:** é necessário investimento em educação permanente e continuada dos profissionais da saúde para que atuem em prol do modelo proposto pela Atenção Primária, pautado na humanização e em relações de vínculo e que garantam uma assistência integral às gestantes e às puérperas.
**Descritores:** Enfermagem; Atenção Primária à Saúde; Saúde materno-infantil; Cuidado pré-natal; Pessoal de saúde

**Resumen:** **Objetivo:** comprender el modelo que orienta la atención a la gestante y recién parida en la Estrategia Salud de la Familia. **Método:** estudio cualitativo. Ocho profesionales de la salud de un equipo de Estrategia de Salud de la Familia participaron en las entrevistas semiestructuradas entre marzo y abril de 2019, en el estado de Rio Grande do Sul, Brasil. Los datos fueron analizados según análisis de contenido temático. **Resultados:** el modelo de atención a la gestante y puérpera en Atención Primaria de Salud desarrollado por los profesionales de la salud es incipiente y predominante en el modelo biomédico, ya que no considera la integralidad, coordinación y longitudinalidad de la atención. **Conclusión:** es necesario invertir en la educación permanente y continua de los profesionales de la salud para que actúen a favor del modelo propuesto por la Atención Primaria, basado en la humanización y las relaciones de vinculación y que garantice la atención integral a las gestantes y puérperas.
**Descriptores:** Enfermería; Atención Primaria de Salud; Salud materno-infantil; Atención prenatal; Personal de salud

## Introduction

Public policies aimed at comprehensive health care for women are a priority. Their purpose is to reduce indicators of cesarean deliveries, encourage good practices in childbirth and birth care, ensure sexual and reproductive rights, and reduce maternal mortality.[1] This is a challenge for health systems[2] raising concern also at the international level.[3]

Searching for comprehensive care for women's health, the Ministry of Health created in 1983, the Comprehensive Assistance Program for Women's Health (PAISM). This program was reformulated and sanctioned as the National Policy for Comprehensive Care to Women's Health (PNAISM) in 2003. The principles of the policy are the comprehensive and the promotion of health, proposing the consolidation of sexual and reproductive rights, the improvement of obstetric care

and providing for family planning,[1] which implies a greater commitment to strengthening care approaches and policy management processes.[4]

Together with PNAISM, some strategies were created, such as the *Rede Cegonha*, the Humanization of Childbirth and Birth Program (PHPN), the prevention and treatment of cervical and breast cancer, and also the Surveillance of Deaths of Women in Fertile Age. These strategies aimed at the effective and advances in the reorganization of the Health Care Network (RAS), in the Unified Health System (SUS), and the consolidation of the protagonism of the Family Health Strategy (ESF) and Primary Care (AB) in care management.[4]

Access to health services contributes to the reduction of maternal mortality and the guarantee of comprehensive care to women.[5-6] However, there are gaps regarding aspects of the quality of care provided in Primary Health Care (APS), highlighting the need for studies with this theme.[6]

Therefore, we need to understand the care model that guides the care of pregnant and puerperal women. The identification of care models allows reflecting on practices and rethinking the modes of health production developed by professionals.[7] The search for a care model, based on integrality and health needs, in line with the principles of SUS, is a current and important challenge of the Brazilian health system. The debates on how to organize health practices have been intensified in the political and academic areas.[8]

The term care model has several meanings and has been used with different terminological variations, such as attention models, techno-care models or care models, which designate different aspects of a phenomenon. The adaptation of a care model results from a historical-cultural and dynamic process.[8]

The ESF guidelines form a new care model, which provides that practices are guided by the determinants that involve the health-disease process. Also, it considers the individual in his family context as a member of groups and communities and develops actions in the area of Health Surveillance and Health Promotion.[9] In this sense, it is important to understand whether the care for pregnant and puerperal women include the actions proposed in this care model.

Inspired by the Alma-Ata resolutions and SUS principles and guidelines, this model points to the integrality and continuity of care for families and communities. It also provides for the performance of multi-professional teams and the development of relationships based on welcoming and the bond between health professionals and the population in the area covered by the health unit.[9]

The ESF is an essential organization of the health system reorganization process.[8] It is one of the strategies for the qualification of the work process in APS since it is characterized by the definition of the territory and territorialization; by registering the population; for the implementation of health actions and the reception as a device for access to the health service and care technologies.[10] Since the care model proposed by the ESF considers the territory and the reception, this strategy enables comprehensive care for pregnant and puerperal women.

Concerning the importance of identifying the models of health care for pregnant and puerperal women in APS and rethinking the work process in APS, the research question of this study was: How the care for pregnant and puerperal women is being developed in APS in the perception of health professionals? This study aims to understand the model that guides care for pregnant and puerperal women in the ESF.

## Method

This is qualitative research developed with a team of health professionals from an ESF, located in a municipality in Rio Grande do Sul, Brazil. The health team had ten professionals and they were a doctor, three nurses, a nursing technician, and five community health agents.

We invited the ten professionals; however, only eight of them accepted to participate in the study. At the time of information collection, a community agent was on sick leave and the nursing technician refused to participate. Thus, four professionals from higher education and four from technical education were interviewed.

The selection criteria for the participants were: health professionals from the ESF who provided care to pregnant and puerperal women, which included professionals with a higher, secondary, and technical level. We collected the information through a semi-structured interview carried out individually from March to April 2019. The interviews took place on the days when the professionals had team meetings or at times previously scheduled with the researcher, an opportunity when they went to the ESF exclusively for that.

All interviews lasted between twenty-six and thirty-four minutes according to the availability of the participants and were recorded by an audio recorder. Afterward, they were transcribed in full and subsequently analyzed.[11] We ended the interviews when a recurrence of the phenomenon was reached in the testimonies of the participants, ensuring the representativeness of the studied population.[12]

We followed a script during the interviews containing questions related to the identification of participants such as position, professional training, and length of experience. We used the following guiding questions: How do you take care of pregnant and puerperal women? What actions do you take in caring for pregnant and

puerperal women in your area? The initial letters “HEP” (higher education professional) and “SEP” (secondary education professional) was adopted, to ensure the anonymity of health professionals.

The data were analyzed according to the thematic analysis.[11] The research obeyed the ethical principles that establish the rules for conducting research involving human beings, explained in Resolution 466/12 of the National Health Council. Participants signed the Informed Consent Form that contained the information regarding the research. The Research Ethics Committee of the Universidade Franciscana approved this study under opinion 3.019.307, CAAE 02373018.4.0000.5306, issued on November 13, 2018.

## Results

Four of the eight health professionals who participated in the study had a degree in higher education and the rest had completed high school. The higher education professionals who participated were three nurses and a doctor. Two of them were part of a Multi-professional Residency Program, one has the title of specialist and the other had a master´s degree. Four community health agent participants had secondary education.

The length of experience of professionals in the area ranged from one to five years in professionals with higher education and eight to twenty years in professionals with secondary education. From the data analysis, three categories emerged: dimensions of care for pregnant women; care practices in the puerperium, and care actions developed for pregnant and puerperal women.

**Dimensions of care for pregnant women**

The health professional showed care for pregnant women including different dimensions. Among these, some involve physical and mental health and care for their family:

> *She has the whole body that can change. She has a psychological aspect. [...] psychological care is very difficult to do. [...] this care for me is very important [...] We try to look at the whole context of her family. (*HEP*)*

> *We end up playing the role of a psychologist. Many of them go through difficulties of acceptance during pregnancy or even structural, they feel alone, helpless [...] Working since pregnancy, that family's planning, many things can be done to not develop in a way that is harmful to that child. (*HEP*)*

> *I always work a lot with my father. I always say about the importance of the father asking for a work permit that day to accompany on ultrasound [...] this is not only important for pregnant women but the baby. She'll be more secure, she'll be better. [...] it is something transforming even for the family, they start helping each other. (*SEP*)*

Professionals take care not only of physical health but also mental health since they seek to understand how family relationships are established with the pregnant woman. They also recognize the importance of strengthening the social support network for pregnant women and the baby, through the presence of family members during prenatal care.

The care that health professionals develop with pregnant women is shown through an effective welcoming and based on a relationship of trust. Also, they consider the knowledge they have to establish a bond.

> *I try, as I can, to talk to her, welcome her first, try to make her a partner. [...] I try to be as level as possible for the possession of knowledge because it distances the patient. (*HEP*)*

> *I think this bond we have is cool. They trust us a lot. (*SEP*)*

> *The team receives the girls [pregnant women] in a humane and equal way. Since teenagers, adults, or someone who is over 40, with a risky pregnancy. They are all well received. (*SEP*)*

> *We follow the principle of equity. That they need more attention, more care, to keep an eye on them. (*SEP*)*

The professionals demonstrated their care with the pregnant women also during the control over the frequencies in the prenatal consultations and the performance of exams and vaccines. This control is exercised by professionals to ensure the health of pregnant women and the baby.

> *We have very strict control. We have a high rate of drugs and alcohol. If they are absent [in consultations], they know that we have called the Tutelary Council. (*HEP*)*

> *I take the pregnant record, see if they are doing prenatal care, because many of them do not do it, or they skip some of the appointments. I see if they did prenatal care that month if they had a vaccine if they have a vaccine to do. (*SEP*)*

> *We are always checking the pregnant woman's record, the consultation record, seeing if she is coming frequently for prenatal care. (*SEP*)*

The care for pregnant women proved to be broad since it has the physical and psychological dimensions and the family context. Professionals recognized that to establish care, they need to establish bonds and practices that promote welcoming.

Also, care is observed through strict control of pregnant women in the

monitoring of prenatal care and in carrying out examinations and vaccines, sometimes having a punitive character when complaints occur. These actions reinforce a technical care model that interferes with the establishment of trusting relationships and weakens the bond between pregnant women and professionals.

**Care practices in the puerperium**

Regarding the care practices in the puerperium, the professionals reported that the puerperal women are attended when there is time on the team's work schedule and that their care is under the responsibility of the ESF nurse. However, puerperal women can seek the ESF in case of doubts, as expressed in the following reports:

> *When it's possible. When the agenda allows us because the agenda here is very busy. Whenever you need you can come here to attend to breastfeeding, to attend to something for the baby, or something different. (*SEP*)*

> *Puerperal women do not have more direct action by the health worker. We go to the residence when the newborn (NB) and the puerperal woman arrive home. [...] And then, what we care for most is the NB. [...] Then, she is sent to the unit for the first return visit, but this is with the nurse. (*SEP*)*

> *We have a childcare group, from six months to five years old, the nurse who takes care. [...] But that was a good thing because you know that until she is six months old, she receives care. Even if you don't get it, you go and look at the agenda, see if it was that day. Look at the system as it is. (*SEP*)*

Also, the care practices of professionals in the puerperium are centered on care for the newborn. Thus, the needs of women are not recognized by professionals.

> *The first thing is to see if they have already done the first consultation. That is them with the baby. And make that first appointment, which they usually don't. See if they did the heel-stick test. (*SEP*)*

> *We do not have difficulties with the puerperal women, because as they are already used to it, they always finish the prenatal and already come to do the heel-stick test and it goes on. [...] So, there is no problem with the mothers. (*HEP*)*

> *With puerperal women, it is more difficult. They come with a focus on the baby. It is difficult for us to revert and not just talk about the child. [...] It is difficult for us to look back at them. [...] It is difficult because they are very focused on the baby. (HEP)*

On the other hand, one of the professionals expressed concern about the mental health of the mothers. He expressed the importance of puerperal women being aware of the existence of services that support them in situations such as postpartum depression.

> *I think the importance of postpartum consultation to evaluate those things that I said, about postpartum depression. And there is also a psychiatric emergency service for pregnant and puerperal women. And the puerperal woman needs to know that she has this psychological support. (HEP)*

Professionals consider important care during the postpartum period. However, care practices are not fully developed for puerperal women, as they are centered on the baby's health care. We can observe that they are attended when there is time on the professionals' agenda and there is a transfer of responsibilities from the care of the team of professionals to a single professional.

**Care actions developed for puerperal and pregnant women**

This category highlights the actions developed by professionals in the care of puerperal and pregnant women. Thus, care actions include performing procedures, exams, and consultations:

> *If a woman comes here to take a quick pregnancy test and it is positive, we already start prenatal care. [...] We do a quick test, provide the tests for confirmation, order the ultrasound, order the beta-HCG [human chorionic gonadotrophin hormone] test, and all the tests that prove the pregnancy. [...] Rapid tests for HIV [human immunodeficiency virus], syphilis, hepatitis B, hepatitis C. We provide the record, complete all nursing consultations for pregnancy, medical consultation during pregnancy. (*HEP*)*

> *[...] nursing consultation, medical consultation. Then, these procedures, dressings, injection, inhalation, preventive collection, rapid tests, exams, and general consultations are offered. (*HEP*)*

Health education is another care action developed by professionals, which occurs at different times and spaces. Professionals perform this activity during collective meetings with pregnant women, in nursing consultations and home visits:

> *We have monthly pregnant groups. [...] From the bath, hygiene care, the importance of preventive care, care for the newborn, with the umbilical stump, the importance of breastfeeding, vaccination. (*HEP*)*

> *We develop the groups of pregnant women, which take place monthly, and have the participation of nursing students. Also, medical students. [...] the occupational therapy people come here to do the beauty workshops. [...] nutrition, healthy eating, about contraception, especially in the puerperal period, about the practice of sex during pregnancy and a series of taboos that*

> *they have and bring with them and that we have to demystify a little bit. (*HEP*)*

> *We have a group. They [pregnant and puerperal women] like it, they come in the group, they participate. They come to bring the babies and do prenatal care. [...] During visits, we guide them from taking care of them every month, to taking care of the baby at birth, the time of delivery, healthy eating, everything that goes to the house, and is always there. (*SEP*)*

> *Health education during the consultation. That we highly value our nursing consultation. [...] Health teaching means teaching healthy habits, health practices, and health prevention to the patient. (*HEP*)*

The care actions of professionals with pregnant and puerperal women were focused on the execution of procedures, the performance of exams, and the control of frequency in prenatal consultations. Although the professionals develop a performance including health education, the pregnancy-puerperal cycle does not occur in an integrated manner, given that the puerperal women do not have their health needs met.

Furthermore, the care model that guides the care for pregnant and puerperal women in APS is mainly centered on the doctor and the nurse, who are the reference professionals for women.

## Discussion

The humanization of care to pregnant and puerperal women need to overcome several challenges in the health systems such as the educational training of health professionals, which is based on an interventionist model, centered on the doctor.

Thus, academic training needs to include changes in the paradigm of women's health care to be comprehensive.[13]

The biomedical model remains dominant in prenatal care in family health units. This model is important for effective and quality care, as long as it is not developed exclusively with body care and a biological approach.[7]

Only through integrated practices considering the subjective, social, economic, and cultural dimensions of pregnant women and their families, the development of quality prenatal care will be possible.[14] The practices are not only related to the way women are treated or welcomed but also with the comprehensive care that is offered throughout the gestational period.[15]

The excessive valuation of care based on strict control of the frequency of consultations, tests, and diagnoses is due to the predominance of the biomedical model. Thus, there is a need to overcome this model by health professionals to achieve humanized and comprehensive care for pregnant and puerperal women.

Prenatal care should not be based merely on consultations and requesting exams since the development of strategies that include welcoming and identifying health needs contributes to establishing a bond between pregnant women, family members, and health professionals.[16] Therefore, we need a care model that meets the ESF proposal demands embracement and actions based on the humanization of care.

The work proposal of the ESF is to work as a team through the articulation of different knowledge and practices that come together in favor of the production of health care. The isolated work of any professional in the ESF does not cover the complexity of the situations imposed in the daily work.[17] Thus, the care for pregnant and puerperal women still proves to be fragmented, not following the care model proposed by the ESF.

Consequently, health professionals need to incorporate new attitudes into their practices through a work process carried out as a team and that aims at multidisciplinary assistance to guarantee the health and rights of women and their newborns, understanding the attention throughout the pregnancy-puerperal process.[13] In this sense, the attention to pregnant and puerperal women cannot be focused only on the responsibility of the nurse and the doctor.

The devaluation of technical competence and the attribution of greater responsibilities to team professionals who have graduated at a higher level often occurs by the community health agents.[17] When thinking about the logic of ESF care, in which different knowledge is complemented and in which the work process must occur with a multidisciplinary team, the health needs of pregnant and puerperal women become the responsibility of all professionals. In this way, everyone is co-responsible for the population of their territory and needs to take this attitude.

The National Primary Care Policy provides for the development of health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, among others. This policy also advises that such actions should be developed through integrated care practices, carried out by a multidisciplinary team with the population of their territory.[10] When observing that care is centered on the doctor and the nurse, there are limitations to the implementation of the care model proposed by the ESF, which considers essential the teamwork process, with an interprofessional perspective.

It is evident that health promotion and the prevention of diseases and injuries for the puerperal women insufficiently meet their needs. In this sense, the current model does not include comprehensive care for them by ESF professionals. When there is a detachment of bonding and accountability relationships between

professionals and the puerperal woman in the assigned territory, the guidelines for ensuring continuity of health actions and longitudinal care are broken.[10]

The longitudinal care is the continuity of the clinical relationship with the puerperal women over time and permanently. When there is responsibility for care, it is possible to monitor the effects of health interventions and other elements in the life of the puerperal women, preventing the loss of references and reducing the risks of iatrogenesis, resulting from the fragility of the coordination of care.[10]

The puerperium is a period with significant maternal morbidity and mortality. That is why Primary Care is important in developing actions that meet the health needs of women.[3] The limitations in the care for puerperal women are in line with public policies, which depreciate the postpartum, when compared to other phases of the pregnancy-puerperal cycle,[18] to the extent that postpartum care is still centered on newborn care.[6]

In the puerperium, there is a devaluation of the health needs of women because the attention is focused on the baby since there is a shortage of physical examination and anamnesis, guidance and communication are insufficient.[18-19] Sometimes, the evaluation of puerperal women occur outside the period recommended by the Ministry of Health,[20] which negatively interferes with the mother's health.[18-19] Therefore, it is up to health professionals to support pregnant and puerperal women to guide, clear up doubts and answer questions.[15]

The puerperal consultation is an important moment of interventions for the promotion of maternal and child health[19] and for the prevention of risk factors that involve this period, such as postpartum depression,[21] anxiety, and emotional trauma.[3,22] Suicide is one of the main causes of maternal mortality.[23] For this reason, nursing consultation and welcoming when properly performed contribute to improving the woman's mental health. The social support provided by the health

team is a protective factor that reduces the prevalence of the puerperal woman developing depression.[24]

Also, the professionals of the family health teams need to be trained to develop puerperal care, based on technical and scientific knowledge and communication skills. The care for puerperal women need to be guided by ethical principles, quality and that values the woman being in all its dimensions[25], which implies that professionals act with sensitivity in the ESF.[26] Some strategies are the elaboration of common projects of performance in teams and holding periodic meetings to reorganize work processes.[18]

There is also a wide range of resolutive care actions to develop in Primary Care to assist women in the puerperium, through the use of light and low-cost technologies. Some of these actions that reduce maternal morbidity and mortality[6] are the advice and support provided to women for the recovery of pregnancy, for the early identification of pregnancy, and the management of physical and emotional health needs.

For the health needs of pregnant women, the professionals showed concern about the different dimensions of their care, relating it to the physical and mental health and family relationships of the puerperal women. This perception by professionals demonstrates an advance in the model of care offered, but it is still insufficient.

The team showed the concern with the involvement of the father and the family during pregnancy to strengthen the bond with the mother and the baby. However, we did not observe this concern with puerperal women. In this sense, we need to recognize the importance of the role of the family during the puerperium, especially when complications occur, in which the woman has discomfort and difficulty taking care of herself, the baby and the family.[25]

The importance of strengthening and expanding health education is emphasized for the care actions developed by health professionals, reinforcing the insertion of puerperal women. Activities in educational groups can be seen as an important means to overcome the biomedical model.[7]

Health education is an important strategy for care in the pregnancy-puerperal cycle, as it promotes the construction and sharing of knowledge that stimulates autonomy, citizenship and the emancipation of self-care and other care.[27-29] When the groups are performed by a multidisciplinary team and when they address different subjects, they answer the doubts during the consultation.[14]

The government is responsible for the qualification of the workforce for management and health care and the viability of permanent and continuing education of professionals.[10] Therefore, more investments in the training of health professionals are essential for them to exercise their care practices guided by a care model that meets the health needs of pregnant and puerperal women, based on humanization and multidisciplinary teamwork.

The limitation of this study was the participation of only a team of ESF professionals in the municipality where the study was conducted. We need more studies involving different teams to avoid generalizations about the care model.

## Conclusion

We concluded that the care model for pregnant and puerperal women developed in APS by professionals is still centered on the biomedical model. There is concern about the technical procedures and control over the frequency of prenatal consultations with the doctor and the nurse, to the detriment of comprehensive, humanized care, which considers biopsychosocial aspects.

When developed through the establishment of bonding, welcoming, and humanizing relationships, the care actions provide the identification of the health needs of pregnant and puerperal women, ensuring integrality. However, when the woman starts the puerperal period, this bond breaks so that she becomes invisible to the professionals, and the responsibility is transferred to the nurse. Thus, the work process in the ESF does not match the perspective of multi-professionality and the sharing of responsibilities of health professionals with pregnant and puerperal women in the territory.

Therefore, there are few actions developed with the puerperal women and, when they occur, they are centered on the health of the newborn. Thus, the model that is being developed does not significantly contribute to the reduction of maternal mortality since it does not ensure longitudinal care and coordination of care for the puerperal women, which goes against the objective of public policies and the proposed health model.

Therefore, investments for the permanent and continuing education of professionals have a positive impact on care practice and, consequently, on the qualification of care for this population. Even if health education actions are developed by professionals, they need to be encouraged as to the participation of pregnant and puerperal women.

More studies about the dynamics of the other teams of ESF professionals may point out other aspects related to the work process and the care model for pregnant and puerperal women, which are not shown here. We also suggest expanding investigations on the theme from the perspective of pregnant and puerperal women.

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