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Adherence to puerperal consultations in an outpatient clinic of a teaching hospital

Adesão à consulta puerperal em um ambulatório de hospital de ensino

Adhesión a la consulta puerperal en un ambulatorio de un hospital universitario

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Objective: to identify the prevalence of adherence to puerperal consultations and associated factors. **Method:** cross-sectional quantitative study carried out from August to December 2019 in an outpatient clinic of a teaching hospital in the interior of the state of Minas Gerais, Brazil, through interviews and analysis of medical records. Descriptive statistics were performed, as well as F Test and Logistic Regression. **Results:** 109 puerperal women participated, and adherence to the puerperal consultation was 37.6%. The following were associated with adherence: women with higher education, who did not live with a partner, who received prenatal care at the institution and primiparous women. Primiparity was the only variable that was significant in the logistic regression. The criteria for scheduling appointments at the institution, except the fact of having prenatal care on site, were not significant for greater or lesser adherence. **Conclusion:** the puerperal consultation is a tool for preventing maternal and child health problems, but the low rates point to the need to rethink puerperal care.
Descriptors: Postpartum period; Referral and consultation; Patient compliance.

Objetivo: identificar a prevalência de adesão à consulta puerperal e fatores associados. **Método**: estudo quantitativo transversal realizado no período de agosto a dezembro de 2019 em um ambulatório de hospital de ensino no interior de Minas Gerais, através de entrevista e análise prontuários. Realizou-se estatística descritiva, e também Teste F e Regressão Logística. **Resultados**: participaram 109 puérperas, e a adesão à consulta puerperal foi de 37,6%. Foram associados à adesão: mulheres com maior escolaridade, que não viviam com companheiro, que realizaram o pré-natal na instituição e primíparas. A primiparidade foi a única variável que se mostrou significativa na regressão logística. Os critérios para agendamento da consulta na instituição, exceto o fato de terem o pré-natal no local, não foram significativos para maior ou menor adesão. **Conclusão**: a consulta puerperal é ferramenta de prevenção de agravos na saúde materno-infantil, mas os baixos índices apontam a necessidade de repensar a assistência puerperal.
Descritores: Período pós-parto; Encaminhamento e consulta; Cooperação do paciente.

Objetivo: identificar la prevalencia de adhesión a la consulta puerperal y los factores asociados. **Método:** estudio cuantitativo transversal realizado en el período de agosto a diciembre de 2019 en un hospital ambulatorio de enseñanza del interior de Minas Gerais, a través de entrevista y análisis de historias clínicas. Se realizó estadísticas descriptivas, así como la Prueba F y la Regresión Logística. **Resultados:** Participaron 109 puérperas y la adhesión a la consulta puerperal fue del 37,6%. Se asociaron a la adhesión: mujeres con mayor escolaridad, que no vivían con pareja, que realizaban el prenatal en la institución y las primíparas. La primiparidad fue la única variable que resultó significativa en la regresión logística. Los criterios para agendar la consulta en la institución, excepto el hecho de tener el prenatal en el local, no fueron significativos para una mayor o menor adición. **Conclusión**: la consulta puerperal es una herramienta de prevención de los daños en la salud materno-infantil, pero los bajos índices apuntan a la necesidad de revisar la asistencia puerperal.
Descriptores: Periodo posparto; Derivación y consulta; Cooperación del paciente.

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INTRODUCTION

The puerperium or postpartum period begins shortly after the baby is born and the placenta is delivered, and corresponds to the period in which physical, hormonal, psychological and social changes caused by pregnancy and childbirth in women tend to return to normalcy of a non-pregnant state. For this reason, a precise period of time is not delimited and varies among individuals[1].

During this involutive process, of indefinite duration, the hormonal and immunological alterations in the woman's body are significant. In the search for homeostasis for her recovery to the non-pregnant condition, the woman's immunity tends to drop, predisposing her to infections, and mood swings are also noted due to sudden hormonal changes[2]. Thus, the puerperal period can be understood as a period of intense physical and emotional vulnerability.

According to data from the Brazilian Department of Informatics of the Unified Health System (DATASUS), in 2019, there were 1576 maternal deaths (during pregnancy or up to one year after childbirth) and, of these, 939 occurred in the puerperal period (59, 6%), with 53.7% occurring in the immediate postpartum period (1st to 10th postpartum day)[3]. Among the causes of death during the puerperium, the most frequent were: hypertensive syndromes (197 cases), previous diseases worsened by pregnancy/delivery/puerperium (189 cases), hemorrhages (92 cases), puerperal infections (55), embolisms (54) , and others[3].

Although physiological, the puerperium is a period of risks, which is why the concept of the fourth trimester of pregnancy has been endorsed, to expand puerperal care[4]. The inclusion of this trimester in care for the pregnancy-puerperal cycle would allow monitoring for a year after the woman confirms the pregnancy[4], and would be justified if it were not centered only on a puerperal consultation, which many women would not attend[4].

In Brazil, the Ministry of Health recommends that, before hospital discharge, the woman be counter-referred to the unit where she received prenatal care, provided with a complete report on the birth and immediate and mediate postpartum evolution, and perform at least one consultation between seven and 42 days after birth[5-6]. Additionally, at least one home visit (HV) is recommended in the first week after discharge; however, if the newborn (NB) has been classified as at risk, the HV must occur in the first three days[5-6].

The World Health Organization (WHO) recommends a minimum of three postpartum consultations: on the third postpartum day, between seven and 14 days and six weeks after delivery, plus a home visit in the first week. It is also advised that the assessment should not be restricted to the physical aspects of the puerperal woman, but should include the emotional state and advice on breastfeeding[7].

Even though only one puerperal consultation is recommended in Brazil, the adherence rate varies from 16.8 to 58%[8,9]; this index is much lower than desired when compared to data from the United Kingdom, where adherence to puerperal consultations has a rate of 91%[9].

It is also noteworthy that carrying out the puerperal consultation is one of the duties of the Primary Health Care (PHC) nurse and, if the puerperal woman is absent, an active search is recommended. However, it is noted that there is no standardization in the conducts both in the consultation and in the search and the commitment to carry out this return is different[10], it is not possible to analyze the assistance provided, and the puerperal return is restricted to the presence or absence in the consultation.

During the period of postpartum adaptation, women may experience complications, due to the appearance of drastic physiological and psychological changes. Thus, this study aims to identify the prevalence of adherence to puerperal consultations and associated factors.

METHODS

This is a quantitative and cross-sectional study on adherence to puerperal consultations and associated factors, among puerperal women assisted at an outpatient clinic of a teaching hospital in the interior of the state of Minas Gerais, Brazil, from August to December 2019.

The institution used as the field of study is a reference for solving high-risk pregnancies, infectious diseases in the pregnancy-puerperal cycle, pathological prenatal care in 27 cities in the region and normal prenatal pregnancies performed in the health district where it is located (around 150,000 inhabitants) and all cities in the Triângulo Sul region of Minas Gerais that do not have a hospital. According to institutional data, during the data collection period, 573 deliveries were performed.

Given the assumption of counter-referral to the unit of origin, as provided for in the regulations[6], the institution schedules returns for: 1) all puerperal women who had at least one prenatal consultation at the institution; 2) teenagers; 3) women who did not have any prenatal consultations; and 4) if the need for a follow-up at the service is detected (intercurrences). Returns can still be scheduled, if the patient wishes. It is also noteworthy that the puerperal consultation is carried out in a different place and date than the childcare return, which is scheduled by the newborn's family after discharge.

The following inclusion criteria were respected: hemodynamically stable, conscious and oriented puerperal women, who had received or expected hospital discharge. Mothers counter-referred to Basic Health Units and/or Family Health Strategy of origin were not included.

Postpartum women who requested an appointment for the insertion of an IUD and/or planning a tubal ligation were excluded.

Data collection was carried out prospectively at two different times. After being oriented and consenting to participate in the study, all puerperal women were interviewed, and data were extracted from medical records. In the interview, sociodemographic, clinical and obstetric data were obtained. In the medical records, information about the delivery, newborn, indication for return to the institution and additional information offered by the participant were collected.

In a second moment, from the list of consultations scheduled for the date, from the hospital's computerized system (electronic medical records), the presence or absence of the scheduled consultation for the included puerperal women was verified, the responses being validated after typing in the database.

Data were collected in a specific instrument, based on information contained in the medical records and tested through a pilot study, which did not demonstrate the need for adaptations. Afterwards, they were coded, stored in an Excel™ spreadsheet, with a double typing technique and subsequent validation. And then it was imported into the Statistical Package for the Social Sciences (version 23). Initially, descriptive analyzes were performed (frequency, mean, standard deviation, minimum and maximum) of the variables and the results were presented in tables.

The dependent variable of the study was adherence to the puerperal consultation. Adherence was considered to have attended the appointment scheduled at the institution. In the effect of each dichotomous variable of interest (independent) analysis of variances was used (Test F) and variables that presented p values lower than 0.05 in the F test, and those that presented normal distribution were evaluated through Logistic Regression. Variables that presented $p<0.05$ in the model were considered significant.

The study was approved by the Research Ethics Committee, opinion number 2,148,698, of June 30, 2017, and its entire development was guided and guided by the Guidelines and Regulatory Norms for Research involving human beings contained in Resolution 466/12/ CNS/MS.

RESULTS

Sample characteristics

Regarding the sociodemographic characteristics of the 109 mothers interviewed, the average age obtained was 25.47 ± 6.93, ranging from 14 to 43 years, with 9.7% being adolescents; 46.8% declared themselves white; 35.8% complete high school education, and 40.4% did not had any paid job. Most were married (59.6%) and lived in the municipality where the study took place (71.6%), as shown in Tables 1 and 2.

Table 1. Postpartum women according to sociodemographic characterization. Uberaba, MG, 2019.

Variables		No	%
Age	Under or equal to 17 years	12	9.7
	Over or equal to 18 years	97	89.0
Race	White	51	46.8
	Black	23	21.1
	Mixed	34	31.2
	Others	1	0.9
Marital status	Married/Civil union	65	59.6
	Single	43	39.4
	Judicially separated	1	0.9
Educational level	Illiterate	2	1.8
	Incomplete Elementary Education	19	17.4
	Complete Elementary Education	20	18.3
	Incomplete High School Education	20	18.3
	Complete High School Education	39	35.8
	Incomplete Higher Education	2	1.8
	Complete Higher Education	5	4.6
Occupation	Housewife	44	40.4
	Student	12	11.0
	Domestic activities	5	4.6
	Activities related to commerce	8	7.3
	Activities that require Higher Education	1	0.9
	Others	36	33.0
Resides in	In the municipality of the study	78	71.6
	Municipalities of the region	31	28.4

As for health conditions and habits, 15.7% reported smoking, 13.8% reported alcoholism, and 2.8% reported using illicit drugs; 64.2% of the mothers had some pathology: hypertensive syndromes, with a percentage of 33.3%; diabetes, 28.2%; hypothyroidism, 23.1%; and obesity and syphilis, with a percentage of 17.9% each. Most puerperal women had a single pathology (55.7%), and 44.3% had more than one.

The mean number of pregnancies was 2.45±1.73, ranging from one to 10; 35.8% were primiparous, the mean number of deliveries, 2.15±1.56 ranging from zero to nine; the mean number of miscarriages was 0.28 ±0.58, ranging from zero to three. The mean number of

prenatal consultations was 7.32±2.63 consultations, ranging from zero to 13; three mothers (2.8%) did not undergo prenatal care, and 14% had fewer than six consultations, according to data in Table 2.

Regarding the place of prenatal care, 17.9% were carried out in Primary Health Care units (UBS or ESF), 61.3% in the outpatient clinic of the teaching hospital, 17.9% started prenatal care in Primary and did another part in the institutional outpatient clinic; and 2.8% in private clinics. Thus, 79.2% of the interviewees received prenatal care at the institution, while 20.8% at other services. In 64.2% of pregnancies, they were classified as high risk.

Table 2. Postpartum women in terms of mean, standard deviation, minimum and maximum values of variables related to obstetric history. Uberaba, MG, 2019.

Variables	Mean	Standard Deviation	Minimum	Maximum
Age	25.47	6.93	14	43
No. of pregnancies	2.45	1.72	1	10
No. of childbirths	2.15	1.56	0	9
No. of miscarriages	0.28	0.57	0	3
No. of prenatal consultations	7.32	2.63	0	13

In the resolution of pregnancies, 53.2% had natural delivery, and of these, 31.2% had perineal laceration, 14.7% episiotomy and 54.1% maintained the integrity of the perineum, and 46.8% had cesarean delivery. Also, 7.3% had complications during childbirth or the puerperium, during hospitalization; 37.6% attended and 62.4% did not attend the scheduled return. Data related to labor, delivery and puerperium are presented in Table 3.

Table 3. Postpartum women regarding labor, delivery and puerperium. Uberaba, MG, 2019.

Variables	Yes		No	
	No	%	No	%
High risk pregnancy	70	64.2	39	35.8
Normal pregnancy	58	53.2	51	46.8
Complications childbirth/Puerperium during hospitalization	8	7.3	101	92.7
Postpartum consultation	41	37.6	68	62.4

Adherence to puerperal return

Of the reasons for the return being scheduled at the institution, 77% were due to having already performed prenatal care at the institution; 11% for being teenagers; 7.3% due to medical request due to complications during pregnancy and/or childbirth and/or puerperium and 2.7% due to lack of counter-reference (postpartum women who did not undergo prenatal care).

In the factors related to adherence to puerperal consultations, there was a statistical association for: postpartum women with higher education (p=0.026); who do not live with a

partner (p=0.043); primiparous (p=0.039); and who received prenatal care at the institution (p=0.012), as shown in Table 4.

Table 4. Association of adherence to puerperal consultation with sociodemographic, clinical and obstetric variables, Uberaba, MG, 2019.

Variable	Attended the consultation		Did not attend the consultation		p
	No	%	No	%	
Age <18 years	4	3.7	8	7.3	1.000
Age >18 years	37	34.0	60	55.0	
Race/White	22	20.2	29	26.6	0.323
Race/Not white	19	17.4	39	35.8	
Lives with a partner	19	17.4	46	42.2	**0.043**
Does not live with a partner	22	20.2	22	20.2	
Educational level above complete High School	23	21.5	23	21.5	**0.026**
Educational level below complete High School	17	15.9	44	41.1	
Has a paid job	23	21.7	27	25.5	0.112
Does not have a paid job	17	16.0	39	36.8	
Lives in this municipality	31	28.4	47	43.1	0.517
Lives in other municipalities	10	9.2	21	19.3	
Smoker	6	5.5	11	10.2	0.551
No smoker	34	31.5	57	52.8	
Alcoholic	5	4.6	10	9.2	0.782
Non alcoholic	36	33.0	58	53.2	
Primiparous	20	18.3	19	17.4	**0.039**
Multiparous	21	19.3	49	45.0	
Attended prenatal care at the institution	37	34.9	47	44.4	**0.012**
Did not attended prenatal care at the institution	3	2.8	19	17.9	
High risk pregnancy	31	28.5	39	35.8	**0.065**
Normal risk pregnancy	10	9.1	29	26.6	
Natural birth	18	16.5	40	36.7	0.166
Cesarean birth	23	21.1	28	25.7	
Natural birth with laceration	9	8.3	25	22.9	0.136
Natural birth with no laceration	32	29.4	43	39.4	
Natural birth with episiotomy	7	6.4	9	8.3	0.588
Natural birth with no episiotomy	34	31.2	59	54.1	
Complications during childbirth/puerperium	1	0.9	7	6.4	0.254
No complications during childbirth/puerperium	40	36.7	61	56.0	

In the association of the study variables and adherence to the puerperal consultation, logistic regression was performed. The variables that showed statistical significance in the univariate analysis (p<0.05) were placed in the model: maternal education; not living with a partner; primiparous women and having performed prenatal care at the institution. The variable "pregnancy classified as high risk" was included in the model, due to its near significance (p=0.065). Thus, it was found that just being the first birth was statistically significant. However, all the factors tested behaved as protection against adherence, as shown in Table 5.

Table 5. Logistic regression model between adherence to puerperal consultations associated with sociodemographic, clinical and obstetric variables, Uberaba, MG, 2019.

Variable	Coefficient	(CI 95%)		P
Educational level	0.651	(0.783)	(4.691)	0.154
Partner	-0.821	(0.176)	(1.099)	0.079
Primiparity	1.166	(1.237)	(8.323)	**0.017**
Attended prenatal at the institution	1.266	(0.881)	(14.289)	0.075
High risk pregnancy	1.001	(0.940)	(7.885)	0.065

DISCUSSION

Low adherence to puerperal return was observed when compared to values obtained in a study in the United Kingdom, which recorded the attendance of 91% of puerperal women in the puerperal consultation[9]. The puerperal consultation is a crucial moment to detect, prevent or treat risk factors, as well as to promote healthier habits, and with appropriate interventions it is possible to reduce maternal death rates in the puerperium[11].

In the adherence between the different strata indicated for consultation at the institution (adolescents; who did not undergo prenatal care; who had complications during childbirth/puerperium; or who underwent prenatal care at the institution), no association was found between indication and adherence the consultation. Although adolescence has not been associated with adherence or non-adherence to the consultation, a study points to the association of maternal age with low adherence[12].

Having received prenatal care at the institution is one of the criteria adopted for scheduling a puerperal consultation and had a significant impact. The creation of a bond between professionals/service and the puerperal woman, in prenatal care, delivery and birth, as well as the reception, are considered essential factors for attending the puerperal consultation[13].

The criteria: having had complications during childbirth and/or the immediate puerperium and not having performed prenatal care, did not show statistical significance. However, an investigation found that 25% of the 12 puerperal women who attended the puerperal consultation did so due to complications during the postpartum period[14].

Greater adherence was observed among puerperal women who had more education. This result was similar to studies that showed lower adherence in women with low education[12,15]. A study carried out in the United States pointed out that feeling discriminated against during the hospitalization period directly reflects on low rates of adherence to postpartum return. When investigating reasons why they felt discriminated against, low education was cited more frequently. The mothers reported that guidelines were not understood and not adapted for their understanding[12], an important approach that deserves reflection.

The fact of not living with a partner was associated with greater adherence to puerperal consultations. This data is contradictory, because although it was not the target of analysis, to evaluate the influence of the partner in the puerperal return, the presence of the partner was associated with greater satisfaction with the pregnancy, delivery and immediate puerperium. Their company was also verified as important at these times[16]. Therefore, there are contradictions regarding the presence or not of a partner, which must be analyzed not only from the point of view of existence, but the quality of the relationship. The woman's support network can be through the relationship with the partner or not, for greater adherence and healthy behaviors in this period[17], including the postpartum consultation.

Another reference condition for care at the institution, which was almost statistically significant for adherence, refers to pregnancies classified as high risk. More than half of the mothers assisted had some pathology, with hypertensive syndromes, diabetes, hypothyroidism, obesity and syphilis being the most commonly found conditions. These levels were lower than the results presented in a survey carried out in the state of Maranhão, Brazil, in which almost all of the puerperal women had some pathology during pregnancy[18]. The presence of comorbidities during pregnancy is also a contradictory data, since a study carried out in the state of Rio Grande do Sul, Brazil, indicated that pregnant women classified as high-risk assistance were 45% more likely to not attend the puerperal return[15].

The participation of primiparous women was more frequent. The predominance of primiparous women was also observed in studies carried out in the national[14] and international scenario[19]. A Brazilian study highlighted the importance and need for puerperal follow-up, especially HV for puerperal women who had their first child[20], corroborating the results of this study, which showed an association with greater adherence to puerperal consultations among primiparous women.

The postpartum consultation is a strategic moment, as, in addition to identifying intercurrences such as infections and complications characteristic of this period, it allows professionals to obtain information about the health of the woman and her family, provide guidance on family planning and clarify doubts regarding breastfeeding. maternal[21].

But despite its benefits, low adherence to consultations was observed (37.6%), with rates similar to those found in a study in the state of Mato Grosso do Sul, Brazil[18]. However, another investigation in Southern Brazil showed adherence above 75%[15], showing regional differences in adherence within the Brazilian territory. Although the rate is low, studies indicate that, despite differences, the rate of adherence to puerperal return ranges from 16.8 to 58%[8,9]. But it is still a different reality from the indices of developed countries, such as in the United

Kingdom, where adherence is greater than 90%[8], and in the United States, where it varies from 72%[22] to 91%[12].

However, in order to rethink puerperal care, it is necessary to identify facilitators and barriers to adherence. An American study identified difficulties with transportation, the care required with other children and the non-professional engagement in the active search for absences to identify the reasons as factors for non-adherence[22]. In addition to these factors, it was identified that consultations and fragmented care for the mother and for the newborn hinder adherence[22], since the puerperal woman prioritizes the care of the child to the detriment of her own self-care.

Even though a single consultation is recommended, it appears that this moment alone is unable to provide adequate guidance on counseling on postpartum depression, the need for spacing between births, healthy eating, regular exercise, or changes in sexual response and emotions during the puerperal period, among many other demands and needs[23].

Another impact factor for non-adherence is the lack of adequate information about the return[24]. This data is confirmed by the results of a study carried out at a UBS in Campo Grande, Mato Grosso do Sul, Brazil, which demonstrated that only 24.6% of the interviewees reported having knowledge about what puerperium is and its relevance[18]. Still, another study showed that only 5.6% of puerperal women were advised, during their hospital stay, about the need for a postpartum consultation[25]. These data reflect problems in communication and understanding of information.

In addition to the lack of information about the puerperal consultation being a privileged moment of intervention, it is observed that many puerperal women believe that they are restricted to guidelines regarding family planning[13], and because they do not identify a need, they do not attend.

Puerperal care is often restricted to breastfeeding. As the focus is on the neonate, care for primiparous women, postpartum women with some pathology and postpartum women who have had a cesarean section is also not prioritized by the team. It is common for primiparous women to present: - difficulties and doubts about the postpartum period and about the care of the NB; - pathologies and are at greater risk of developing complications; and - cesarean delivery that require closer monitoring due to the surgical incision. It seems in fact that the look is exclusive to the newborn, which was verified a low rate of puerperal return in the PHC[20], and in case they detect alterations, they seek urgent/emergency services.

This gaze turned to the newborn is observed not only in professional assistance, but in the mother's choice to attend the appointment or not. In this sense, many fail to go to the

consultation because they are focused on caring for the baby[21,26], in addition to feeling well, having to take care of the baby, and having to take care of other children[17]. In addition, during the consultation, many puerperal women feel inattentive because they are taking care of the baby and have the perception that professionals will not have the sensitivity to wait to finish caring for the newborn, such as changing a diaper or breastfeeding, for the orientation[17]. Thus, even if they do attend, they cannot absorb all the guidelines and care.

The puerperium is a vulnerable and crucial moment for the health of the mother-baby binomial and requires a careful and committed look from health professionals, since risks at this stage can lead to fatal outcomes. For this, it is necessary to emphasize the importance of the puerperal consultation, identify absentee women, and seek to understand factors associated with adherence and non-attendance. In addition, the importance of trained and qualified professionals is highlighted to recognize complications, intervene at the right time, solve doubts and guide the best conducts, with a view to promoting a better quality of life.

CONCLUSION

Low adherence to puerperal consultations was observed. The following were associated with adherence: women with higher education, who did not live with a partner, who received prenatal care at the institution and primiparous women. Primiparity was the only variable that was significant.

The results of this study point to the need to rethink puerperal care, from the perspective of women and, as an alternative, it is important to emphasize the consultation during hospitalization and seek to schedule returns of the puerperal woman and NB on the same date and place to optimize displacements and increase membership.

As a limitation of the study, external validity is pointed out, since, due to the fact that it was carried out in a single institution, the data cannot be generalized to other realities. On the other hand, the phenomenon of professionals' adherence and attention in the puerperal consultation needs to be further explored. And the study presented here can be an awakening to understanding in other realities and locations.

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