Esc Anna Nery (print)2013 Jul-Sep; 17 (3):446 - 454

ORGANIZATIONAL STRUCTURE OF POSTPARTUM CARE IN FAMILY HEALTH STRATEGY[a]

Estrutura organizacional da atenção pós-parto na estratégia saúde da família

Estructura organizacional de la atención posparto en la estrategia salud de la familia

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ABSTRACT

The study aims to describe features of the organizational structure of post-partum care in the Family Health Strategy, based on requirements present in the national health policy relating to the infrastructure, personnel, care actions and management. The study is quantitative, descriptive and cross-sectional, and was undertaken in 55 Family Health Strategy clinics in Cuiabá, Mato Grosso (MT), through interviews and descriptive statistical analysis. The majority of clinics meet the requirements of physical infrastructure and the offer of actions in the post-partum period. There are limitations in the offering of nursing consultations, group education, and oral contraception for use in the post-partum period. Material for the prevention of cervical cancer is not always available in the clinics; neither are doctors. The scheduling of post-partum consultations is not routine and data from the information system is not habitually used in planning this care. It is necessary to invest in improving the organizational structure for post-partum care to improve in quality.

Keywords: Structure of services; Postpartum period.

RESUMO

Objetivou-se descrever atributos da estrutura organizacional da atenção pós-parto na Estratégia Saúde da Família, a partir de quesitos presentes na política de saúde nacional, relativos à infraestrutura, pessoal e a ações assistenciais e de gestão. Estudo quantitativo, descritivo e transversal, realizado em 55 unidades da Estratégia Saúde da Família de Cuiabá, Mato Grosso, mediante entrevista e análise estatística descritiva. A maioria das unidades contempla quesitos de infraestrutura física e de oferta de ações no pós-parto. Há limitações na oferta de consultas de enfermagem, de educação grupal e de anticoncepcional oral de uso no pós-parto. Nem sempre há disponibilidade de material para o preventivo de câncer de colo uterino e de médicos nas unidades. O agendamento da consulta pós-parto não é rotineiro, e dados do sistema de informação não são habitualmente usados no planejamento dessa atenção. É necessário investir na melhoria da estrutura organizacional para que a atenção pós-parto ganhe qualidade.

Palavras-chave: Estrutura dos serviços; Período pós-parto.

RESUMEN

Objetivo: describir los atributos de la estructura organizacional de la atención posparto en la Estrategia Salud de la Familia, a partir de definiciones de la política nacional de salud relacionadas con infraestructura, personal y acciones de asistencia y gestión. Estudio cuantitativo, descriptivo y transversal, realizado en 55 unidades de la Estrategia Salud de la Familia en Cuiabá, Mato Grosso, a través de entrevistas y estadística descriptiva. La mayoría de las unidades incluyen requisitos de infraestructura y de oferta de acciones en el periodo posparto. Existen limitaciones en la oferta de consultas de enfermería, de educación en grupo y de anticonceptivos orales de uso posparto. No siempre hay disponibilidad de material para la prevención del cáncer uterino y de médico en las unidades. La programación de la consulta posparto no es una práctica y los sistemas de información no son comúnmente utilizados en la planificación de esa atención. Es necesario invertir en la mejora de la estructura organizacional para ampliar la calidad de la atención posparto.

Palavras-clave: Estructura de los Servicios; Periodo de Posparto.

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Submitted on 06/20/2012
Resubmited on 10/15/2012
Accepted on 07/15/2013

INTRODUCTION

The post-partum period is an essentially female experience, but also has to do with men and with the families which share it. For the woman, this phase of her reproductive life corresponds to the physical recovery from the pregnancy and the process of entering motherhood. This interlaces organic, psycho-emotional, behavioral, relational and socio-cultural changes. For the man, it encompasses the experience of fatherhood and the repercussions which the birth brings to him and the family, including new responsibilities, worries, feelings, values and behaviors[1]. In the family, the period is characterized by changes associated with the insertion of the new member of the family, which affects its everyday organization and dynamics[2].

In the post-partum period, the women, men and families involved in the experience have varying health needs. In spite of hoping that it may be healthy, physical, subjective, relational and social problems may appear. The problems and the vulnerabilities which cause them must be considered by the health services, in particular those of Primary Care, which have the social responsibility of promoting family health and, as part of this, reproductive health.

The Brazilian health policy establishes specific guidelines, actions and strategies for reproductive health care[3-7], directed at women, the new-born and at men, situating primary care matters in the post-partum care, and indicating the corresponding structure and assistential and managerial organization.

To this purpose, various proposals are presented on: physical and material infrastructure; personnel; care actions; organization of access, including to other services in the health network; and measures for managing the teams, the care, and the means which viabilize them[3-9].

Suitable physical and material infrastructure promotes good care practices, as the quality of these is sensitive to the environmental and structural conditions. The ensuring of space, furniture, equipment and material resources favors the carrying-out of appropriate actions, capable of resolving issues, as well as supplying conditions for work[10].

So as to promote the health of mother and child, and to avoid their deaths, there needs to be a sexual and reproductive health network which is adequate, integrated and regulated, with wide support from physical, material, human, technical and financial resources. Adequate resources are one of the requirements for implementing comprehensiveness[7].

The Brazilian Ministry of Health (MS) suggests for the Family Health Strategy (ESF) clinics a particular structure with given care characteristics and technical, administrative and logistical support, according to the number of teams and the population covered. More specifically, for care activities, for clinics with a team, it stipulates at a minimum, as part of the physical structure, a specific room for procedures, at least two consultation offices, for medical/nursing staff, one having a bathroom, and an area specifically for health education activities[8]. These requirements are considered indispensable for good care in the post-partum period[7].

To this end, the ESF clinics must also have available material for checking vital signs (sphygmomanometer and clinical stethoscope); measurement of weight/height (weighing scale for adults with anthropometric ruler); undertaking gynecological examinations and collection of biological material for the Papanicolaou test (gynecological examination table, examination light, two-tier steps, Cheron uterine dressing forceps).

In addition to this, the clinics must have available the medications and items, such as oral contraception for post-partum use, ferrous sulphate, vaccines (the double adult type - dT, triple viral vaccine and hepatitis B), material for logistic support, such as instruments for recording data (perinatal file cards, file cards for records in the Pre-Natal Information System - SISPRENATAL) and for exchanging information (pregnant/puerperal woman's card) [5].

In the ESF, the team must be made up of, at the minimum, one doctor, one nurse, two auxiliary nurses and/or nursing technicians, and Community Health Workers (CHW) for the covering of the territory. These workers must have an established link with the families under their care responsibility, and vice-versa[9]. To work with reproductive health, the team must be technically prepared for managing technology to do with the area and to carry out humanized actions, actions of clinical support to the woman in the post-partum period, and actions of psycho-emotional and social support for motherhood and fatherhood[3-7].

Post-partum care in primary care includes: user embracement; linking the woman, man and family to the local service; clinical-educative actions monitoring the woman's organic changes; family planning actions, and actions for the prevention of breast cancer, cervical cancer, and sexually-transmissible diseases; continuing support for breast-feeding and care of the new-born; psycho-emotional support for motherhood and fatherhood; information and education directed at health in the post-partum period; and social actions for promoting reproductive health[3,5-7].

For the provision of post-partum care, the MS[5,7] proposes a "First Week of Comprehensive Health", geared towards the clinical-educative care of the woman and newborn in the first week post-partum. For this, it recommends home visits by CHWs and/or nurses in the first week after the new-born is discharged, and in the first three days post-discharge in cases where there is a classification of risk. In this first post-birth contact, the woman must be ad-

vised regarding returning to the service for a consultation between seven and ten days after the birth, and again for a consultation up to 42 days after the birth. For the man, the MS[6] postulates the organization and offer of actions for paternity support and family planning.

For these actions to be effected with good quality, this body[3,5,7,10] stipulates their management, valuing the production and analysis of information on reproductive health which should permit the identification of important health needs, and the monitoring of the services' conditions and the quality of the actions undertaken; the establishing of systematic mechanisms for assessing the services, the actions and the teams' performance; and the systematic and participative planning of goals, actions and strategies.

For accessing the assistance, the MS envisages, among other things, the early monitoring of the woman in the post-partum period by the local service and her linking with the same, and the guaranteeing of referral and counter-referral in the health services' network for the continuity of care actions and the resolution of problems[3,5,7,9].

In spite of these political proposals, there is evidence that the care in the post-partum period in Brazil is not being carried out appropriately, this aspect being associated with the important problem of maternal deaths[7]. The monitoring of the post-partum period by Brazilian local health services has not been undertaken systematically, possibly due to limitations in the services' structure, management and assistence[11], among other aspects.

It is necessary, therefore, to grasp and discuss peculiarities related to the quality of care in the post-partum period in the Unified Health System (SUS), evidencing, among other things, the local health services' structure and operative capacity, their care and managerial components and, what is more, the results obtained.

Focussing on one specific aspect of these peculiarities, this research, carried out in the setting of the ESF in Cuiabá, aims to describe the features of the organizational structure of the post-partum care, considering and discussing the incorporation of certain requirements recommended in the national health policy regarding the physical and material infrastructure, the personnel, and the managerial and care actions.

METHODOLOGY

This descriptive, quantitative and cross-sectional research was undertaken based on data collected in March 2011 in 55 ESF clinics in Cuiabá, Mato Grosso, out of a total of 65 existing there at that time.

The inclusion criteria adopted for the clinics were: to have been functioning for a minimum of one year, a time considered necessary for its structuring; and to be situated in the urban area. The research's principal informant was the nurse in each clinic. 55 nurses participated. Of the 57 clinics which met the above-mentioned criteria, two were excluded because the nurse was not available to participate in the research.

Only information on the technical training of the doctors was collected from these professionals, 43 of them participating. Information on the technical training of the auxiliary nurses and/or nursing technicians and self-assessment of their preparation for post-partum care actions was collected from 102 of them. Doctors and auxiliary nurses and/or nursing technicians participated in activities in the ESF clinics during the data collection period.

In Cuiabá, the ESF clinics have individual (exclusive) or linked physical structures, with areas shared between two clinics. In each clinic there is a minimum team, as proposed by the MS, working 8 hours a day from Monday to Friday; working these hours is linked to a value added to the salary.

The data was collected through interviews, with a structured instrument, previously developed and tested, containing closed questions on the physical and material structure, the staff, the actions offered, the organization of access and the management actions, related to the requirements of pre-natal and post-partum care selected from those proposed by the MS[3-9]. In this article, the requirements related below - related directly to the care - were worked upon.

On the subject of the physical infrastructure, the availability and unavailability of spaces was considered, differentiating the specific ones (used only for the purposes for which they were designed) from the adapted (locales considered unsuitable), and those for the exclusive use of the clinic from those whose use is shared between linked clinics. The minimum physical elements envisaged for clinical-educative care in the post-partum were investigated[5,7,8]: a specific procedures room for carrying out the pre-natal consultation; a specific room for vaccinations; the existence of two consultation offices (doctor and nurses), and of at least one with a bathroom; and a specific area for educational groups.

In relation to the permanent materials[a] for use in post-partum care[5,7] continuous availability, intermittent availability and unavailability was ascertained for: stethoscopes and sphygmomanometers, weighing scales for adults, examination tables, gynecological examination tables, examination lamps for gynecological examinations and two-tier steps alongside the examination table and gynecological examination table. Only the materials considered to be in conditions appropriate for use were considered as 'available'.

In relation to the consumable materials, medications, other products, and printed materials used in routine post-partum care[5], the continuous availability, intermittent availability and unavailability of the following was

considered: material for collection of samples for Papanicolaou tests (gloves, speculums of all sizes, spatulas, brushes, blade, fixative), oral contraception for use in the post-partum period, ferrous sulphate, Hepatitis B vaccine, dT vaccine, record cards for registering attendances in the SISPRENATAL, record cards specific to pre-natal/post-partum attendance, created by the team or by the Municipal Health Department (SMS), and the pregnant/puerperal woman's registration card.

In relation to the staff, the following requirements were surveyed[7,9]: availability or temporary unavailability in the workforce, in 2010, of the doctor, the nurse, of the two nursing technicians and/or auxiliary nurses, and of the CHW for all the micro-areas; change, or not, of the doctor, the nurse, the nursing technicians and/or auxiliary nurses and the CHW, in the same year; and the specialization of the doctor and nurse in family health or collective health. Also investigated was the participation (or not) of the doctor, the nurse and the nursing technicians and/or auxiliary nurses in technical training in issues of reproductive health care, in 2009 and 2010, for a minimum of 16 hours (considered the minimum necessary for an introductory addressing of clinical-assistential aspects of the post-partum period). The investigation proceeded to the nurse's self-assessment on her preparation for post-partum care, in relation to the physical assessment of the woman, her nutritional status, risks, vulnerabilities and emotional aspects, assessment of the new-born, approaching of the father and family, health promotion actions, education in reproductive health, interaction and user embracement. It also proceeded to the self-assessment of the nursing technicians and/or auxiliary nurses regarding their preparation for checking weight, height, blood pressure, immunization, health education, interaction and user embracement in the post-partum period.

In relation to the post-partum care offered by the ESF, there was investigation of the continuous or discontinuous carrying-out of - or non-carrying-out of - the following actions[3,5-7]: home visits in the 1st week post-partum by the CHW and/or nurse; a nursing consultation in the clinic, up to ten days post-partum; a medical consultation in the clinic, up to 42 days post-partum; individual and group educative actions; specific care for the father and family; breast-feeding care; and contacting women who do not attend the post-partum consultations.

In the considering of the organization of access to post-partum care[3,5,7,9] the study took into account the undertaking, or not, of the prior scheduling of the post-partum consultation and of continuity in the monitoring, by the Family Health unit, of women in the post-partum period referred to specialist health services; and the existence, or not, of difficulties in guaranteeing being referred to other services for women in the post-partum phase.

In the considering of post-partum care's management requirements[3,5,7,9], the adoption (or not) of a post-partum clinical protocol was researched; the undertaking, or not, of systematic actions for assessing or planning post-partum care by the team, based on data/information from the information systems; and reference, or not, to targets to be attained in post-partum care.

The study's data-base was constructed with the help of the Epi-Info software, version 3.5.1. The variables were analyzed using descriptive statistics, through measurements of frequency (absolute and relative frequency). The frequency measurements of the four dimensions studied (physical and material infrastructure, personnel, actions, organization of access and management) are presented in Tables 1 to 5.

Table 1. Characterization of the ESF clinics, according to the components of their physical infrastructure. Cuiabá-MT, 2011. (n = 55)

Physical structure	Available				Unavailable
	A specific space. for the exclusive use of a single clinic	An adapted space. for the exclusive use of a single clinic	A specific space. for shared use between two clinics	An adapted space. for shared use between two clinics	
	n (%)	n (%)	n (%)	n (%)	n (%)
Pre-consultation room	22 (40.0)	17 (30.9)	07 (12.7)	05 (9.1)	04 (73)
Specific room for vaccinations	17 (30.9)	-	38 (69.1)	-	-
Consultation office with bathroom	52 (94.6)	-	01 (1.8)	-	02 (3.6)
Consult' offices for dr & nurse	55 (100)	-	-	-	-
Áreas for edu. groups	03 (5.5)	09 (16.3)	03 (5.5)	20 (36.3)	20(36.4)

Table 2. Characterization of the ESF clinics, according to components of permanent materials, consumable materials, medications, items and printed materials. Cuiabá-MT, 2011. (n = 55)

Permanent materials	Available	Not always available	Unavailable
	n (%)	n (%)	n (%)
Stethoscope	51 (92.7)	04 (7.3)	-
Sphygmomanometer	48 (87.3)	07 (12.7)	-
Lamp	54 (98.2)	01(1.8)	01(1.8)
Adult weighing scale	54 (98.2)	01(1.8)	-
Gyn. Exam. table	54 (98.2)	01(1.8)	01(1.8)
Examination table	55 (100)	-	-
Two-tier steps	55 (100)	-	-
Consumable materials. medications and vaccines			
Material: Pap test	13 (23.6)	42 (76.4)	-
Oral contraception for use in post-partum period	18 (32.7)	37 (67.3)	-
Ferrous sulphate	49 (89.1)	06 (10.9)	-
Hepatitis B vaccine	53 (96.4)	02 (3.6)	-
dT vaccine	52 (94.6)	03 (5.5)	-
Printed materials			
Pregnant/puerperal woman's card cardcarda gestante-puérpera	54 (98.2)	01(1.8)	-
Record card for reg. of attendances on SISPRENATAL	52 (94.6)	03 (5.5)	-
Pre-natal/post-partum record card	26 (47.2)	04 (7.3)	25 (45.5)

The study respected the ethical precepts of research involving human beings, and was approved by the Júlio Muller University Hospital (HUJM)'s Research Ethics Committee, under decision nº 883/CEP-HUJM/2010.

RESULTS AND DISCUSSIONS

In relation to the physical structure, it was observed that the majority of ESF clinics in Cuiabá have a pre-consultation room, consultation offices for the doctor and nurses, with specific spaces, and for the exclusive use of a single clinic, with at least one consultation office with a bathroom existing in the majority of clinics. However, the number of clinics with areas adapted for pre-consultation activities, and of clinics which do not have areas for health education in groups, is relevant.

The great majority of ESF clinics have usable stethoscopes, sphygmomanometers, a gynecological examination lamp, adult weighing scales, a gynecological examination table, an examination table, with two-tier steps next to these two. There is routinely ferrous sulphate, dT and Hepatitis B vaccines, the pregnant/puerperal woman's registration card, and record card for registering attendances in the SISPRENATAL. One finds, however, an important limitation in relation to the continuous availability of consumable materials for undertaking prevention of cervical cancer, of oral contraception for use in the post-partum period, and of the record card specifically for pre-natal/post-natal attendances created by the team or by the SMS.

The unsuitable condition of the physical infrastructure is associated with the fact that most of the ESF clinics in the municipality were allocated to buildings which had not been built for this purpose. This tendency is encouraged by the fact that the national criteria for implantation of ESF teams do not include the necessity for a physical structure suited to established parameters.

In the ESF of Cuiabá, the pre-consultation constitutes the user's first moment of attendance by the service. Through this practice, in addition to the previous production of some clinical information stipulated for the post-partum consultation, and of the consideration of situations which require immediate access, the attendance must embrace the puerpera and her family and seek to widen their access to the service's actions. For this, it is essential for there to be an exclusive space in which the service users may be attended with privacy and with time available for this approach.

Group education in health figures among actions prioritized in the national reproductive health policy[4-7]. It is seen as essential for the promotion of health directed at the emancipation of those involved in reproduction, being

Table 3. Characterization of ESF clinics, according to availability, turnover and qualification of the staff. Cuiabá-MT, 2011. (n = 55)

Availability of the professional*	**Yes**	**No**
	n (%)	**n (%)**
1 Nurse	54 (98.2)	01 (1.8)
1 Doctor	42 (76.4)	13 (23.6)
2 Nursing tech.s or Aux. nurses	49 (89.1)	06 (10.9)
Complete no of HCWs	23 (41.8)	32 (58.2)
Turnover of professionals in one year*		
Nurse	04 (7.3)	51 (92.7)
Doctor	26 (47.3)	29 (52.7)
Nursing tech. or Aux. nurses**	58(56.9)	44 (43.1)
HCW	04 (7.3)	51 (92.7)
Specialization in Family Health or Collective Health		
Nurse	39 (70.9)	16 (29.1)****
Doctor***	16 (29.1)	27 (49.1)*****
Technical training****		
Nurse	54(98.2)	01(1.8)
Doctor***	15(27.3)	28(50.9)
Nursing tech.s or Aux. nurses**	31 (30.4)	71 (69.6)
Perception of the nurse on her preparation for post-partum care		
Physical assessment of the puerpera	53 (96.4)	02 (3.6)
Assessment of the nutritional status nutricional	55 (100)	-
Assessment of risk and vulnerabilities	51 (92.7)	04 (7.3)
Assessment of emotional aspects	52 (94.5)	03 (5.5)
Approaching of father and family	54 (98.2)	01 (1.8)
Health promotion actions	54 (98.2)	01 (1.8)
Assessment of the new-born	54 (98.2)	01 (1.8)
Education in reproductive health	55 (100)	-
Interaction and user embracement	55 (100)	-
Perception of Aux. nurse or Nursing tech. on her preparation for the post-partum care**		
Verification of weight and height	102 (100)	-
Verification of blood pressure	102 (100)	-
Immunization	99 (97.1)	03 (2.9)
Health education actions	94 (92.2)	08 (7.8)
Interaction and user embracement	98 (96.1)	04 (3.9)

* Data for 2010.
** n = 102
*** n = 43
**** Of the 16 nurses, 9 have a further specialization, in addition to Family Health or Collective Health.
***** Of the 27 doctors, 8 have a further specialization, in addition to Family Health or Collective Health.
****** In the area of reproductive health in the years 2009 and 2010, for a minimum of 16 hours.

Table 4. Characterization of ESF clinics, according to care actions offered for the post-partum period. Cuiabá-MT, 2011. (n = 55)

Actions for the puerpera and her family	Yes/Always	Not always	No
	n (%)	n (%)	n (%)
Home visit in the first week post-partum by the CHW	54 (98.2)	01 (1.8)	-
Home visit in the first week post-partum by the nurse	49 (89.1)	04 (7.3)	02 (3.6)
Nurse consultation in the clinic. 7 to 10 days post-partum	27 (49.1)	12 (21.8)	16 (29.1)
Doctor consultation in the clinic. up to 42 days post-partum	48 (87.3)	06 (10.9)	01 (1.8)
Individual educational action	53 (96.4)	02 (3.6)	-
Group educational action	13 (23.6)	11 (20.0)	31 (56.4)
Specific care directed at the father and family	34 (61.8)	16 (29.1)	05 (9.1)
Care directed at breastfeeding	53 (96.4)	-	02 (3.6)
Contact those who fail to attend	50 (90.9)	04 (7.3)	01 (1.8)

Table 5. Characterization of the ESF clinics, according to organization of access and management. Cuiabá-MT, 2011. (n = 55)

Access and Management*	Yes	No
	n (%)	n (%)
Prior scheduling of post-partum consultation	27 (49.1)	28 (50.9)
Continuity of monitoring by USF of high risk puerperas. referred to other services	51 (92.7)	04 (7.3)
Difficulty in referring puerperas	04 (7.3)	51 (92.7)
Adoption of clinical protocol for post-partum care**	46 (83.6)	09 (16.4)
Local and systematic planning and evaluation of post-partum care. by the team	37 (67.3)	18 (32.7)
Systematic use of data from information systems	30 (54.5)	25 (45.5)
Reference to targets to be achieved in relation to post-partum care	51 (92.7)	04 (7.3)

* Data mentioned are for the year 2010.

** Ministry of Health, Municipal Health Department or created by the team.

a space where these can exchange experiences and knowledge among each other and with the health professionals[13]. For this to take place, among other things, it is important for the space and the appropriate resources to exist. The lack of these does not inviabilize it, but does hinder the use of a participative, dialogical educative approach, and its systematic character, which aspects are consistent with post-partum care in a framework of comprehensiveness and humanization.

The fact that the great majority of ESF clinics in Cuiabá have permanent materials, medications and vaccines recommended for care in the post-partum period is positive. The lack of regularity in the availability of consumable materials necessary for the undertaking of prevention of cervical cancer is an important problem, this care being highly recommended in the post-partum care for the woman[3,5]. In the same way, the irregular offering of contraceptives for use in the post-partum period compromises the appropriate support for planning of management and the recommended intrapartum interval[5].

One study[9] addressing how nurses in traditional health centers in Cuiabá perceive the local infrastructure and its influence on their practices indicates that the inadequacy of the physical and material structure entails a reduction of the user's access to the service and of the resolutive capacity of the actions; dehumanization and discontinuity of the care; and inviabilization of the offering of certain actions, such as education. This characteristic also compromises professional autonomy, creates dissatisfaction in the worker, and conflicts with service users. In addition to this, it makes it difficult to plan and achieve care goals.

A point on which this and other studies agree[14,15] is the assertion that weak points in the infrastructure and the organization of the health services, in any of their aspects, foster dehumanization of the care, have negative repercussions on the work process, and compromise the quality of the care and the reaching of its objectives.

In line with the national health policy[10], it is the responsibility of the municipal management to meet local demands relating to organization of the primary care network, which includes the availability of infrastructure resources necessary for the effectuation of reproductive health care[3,7] and, in particular, for the post-partum period.

In relation to the staff, it was identified that there is a high level of availability and a low turnover of nurses in the ESF clinics, and that the majority are specialized in family health

or collective health. Regarding the doctors, there is significant turnover and interruption in their availability in the clinics, in addition to a low rate of specialization in family health or collective health and of participation in training in reproductive health. Also significant is the existence of staff shortages of CHWs in the Family Health units (USF) teams and the high turnover and non-specialization in family health or collective health among auxiliary nurses or nursing technicians.

In the municipality studied, the local health workers live with poor employment conditions, with low salaries, discontinuity in central management and with limited valuing of primary care, expressed, among other things, by the lack of a policy for investing in human resources.

For post-partum care, as envisaged in the reproductive health policy[4,6,7], all the workers need to have access to systematic training, with a view to meeting women's, men's, and families' health needs with quality and specificity, even more so considering the new changes projected for the ESF[10].

Inadequate salaries and work conditions, added to aspects of the doctor's professional realization, are factors which discourage this worker's permanence in the ESF, leading to high turnover, difficulties in creating links with the population, and discontinuity of care actions[16].

The lack of a minimum number of HCWs and the turnover of auxiliary nurses and/or nursing technicians in the teams also compromise the actions' continuity and the establishment of links between service users and local clinics. Because of the lack of an effective link, people stop attending regular check-ups[17] and occasional attendance is perpetuated.

In the ESF, all the members of the team are important for adequate care in the reproductive period, the interdisciplinary team being one of the axes of the new model[10]. Its relevancy is emphasized for the comprehensiveness of the health care, as this is provided through the articulation of viewpoints and practices of the various professionals in the teams. Shortcomings in this requirement are considered obstacles to humanized care in reproduction[18].

In relation to the care for women, men and families in the post-partum period, it was found in the research that, generally, the ESF clinics provide the actions recommended in the national policies.

Reference is made to the routine offering of home visits in the first week post-partum, by the CHW and/or nurse, of breast-feeding care and contacting puerperas who do not attend. However, there is an important percentage of non-realization of group education actions regarding the post-partum, actions specific to fathers and to the family, and nursing consultations in the clinics. The post-partum consultations with doctors are also not practised systematically in all the clinics.

Health education is an action which is strategic to innovation in care in the ESF, configured as an important technology for promoting women's, men's and families' active participation in post-partum care, and in promotion of their health. It is also an essential action for directing actions in line with the life context and subjectivity of those involved[13].

It is important for the post-partum nursing consultation to be carried out systematically. It makes possible not only the clinical-educational follow-up of the woman and the new-born, but also fosters the embracement which encourages the linking of the woman, the father and the family to the service and the addressing of their needs.

In relation to the organizing of access, a reduced percentage was found of ESF clinics carrying out the previous scheduling of the post-partum consultation; the great majority, however, follow up the at-risk puerperas who are being monitored in centers of excellence and claim not to have difficulties in referring them to other services.

Regarding the management of post-partum care, it was ascertained that a large proportion of ESF clinics adopt a clinical protocol of post-partum care and the teams assess and plan the care in this phase locally. A low percentage of clinics, however, use data from information systems for this.

To ensure the early initiation of the pre-natal care, it is important to schedule the first consultation shortly after the pregnancy is confirmed. At the end of the pregnancy, scheduling the post-partum consultation is also essential, for the continuity of the actions initiated in the pre-natal phase and for ensuring continuity of the care, above all, to the woman[3,5,7].

The reproductive health policy[3-5,7] values the guaranteeing of referrals, based on the formalization of referral systems and the continuity of monitoring by the ESF clinic of women at higher risk referred to other services, with a view to promoting the actions' continuity and longitudinality, the link and the resolution of the problems.

The link, the continuity and the longitudinality must contribute interdependently to reducing barriers to access, to the ESF itself and other services, and to necessary diagnostic and cure actions in reproductive health. The ESF has the function of organizing flows and counterflows of its users in the network, and must be responsible for their health in any spaces of health care, both when ordering or when monitoring their movement through the health network[17,18].

The planning, as a management practice, must contribute to organizing health actions in a way that meets local needs, especially if supported in specific information and in the evaluation of the care. This applies to reproductive health care[18] and, therefore, to post-partum care.

The production and use of information in this area is an essential instrument for planning, assessment and management of the health services, as it permits the investigation of the local epidemiological profile, the specific recognition of needs, and the assessment of the quality of what is undertaken, favoring the taking of suitable decisions[18]. The evaluation makes it possible for managers and workers to monitor the running of the reproductive health actions and their impact, and to redefine necessary actions[3,4,7, 10].

Appropriate infrastructure constitutes an aspect which is positive for the implementation of actions envisaged for care for the woman, the man, the new-born and the family specifically in the post-partum period. On the contrary, the weak points in the organizational structure of these clinics, referent to the staff and organization of access and management, are limitations on the effectuation of the local policies of health care in the post-partum period.

FINAL CONSIDERATIONS

The study allowed the conclusion that the majority of ESF clinics in Cuiabá have appropriate conditions in terms of infrastructure and the routine offering of post-partum care actions, but that they also present inadequate conditions in terms of availability and qualification of their personnel. The scheduling of a post-partum consultation is not done routinely and data from the information system are not habitually used in planning this care.

There is a counterpoint between the weakness found in aspects of the organization of access to, and management of, the post-partum care and the implementation of the care actions identified in the majority of the city's ESF clinics, suggesting a certain lack of articulation between management and care. It is essential to bring these two aspects closer together for the actions to be developed and carried out in line with the health needs experienced by the woman, the newborn, the father and the family in the post-partum period.

As a result of the study focusing on general requirements recommended for post-partum care, the undertaking of research detailing aspects of the organizational structure of post-partum care in the ESF is suggested, and that these should investigate factors related to the problems found.

Technical-political efforts must be made to improve the quality of the organizational structure of post-partum care, especially considering the implementation of care actions recommended in the policy and their linking to managerial practices which instrumentalize them.

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NOTE

[a] Those which, due to their regular use, do not lose their physical identity, and/or last over two years.[12]