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Perception of women and their partners on the experience of the postpartum period and health care

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ABSTRACT

Objectives: to reveal the perceptions and experiences of postpartum women and their partners during the postpartum period and to analyze the actions developed by nurses in caring for this population. **Methods:** qualitative study using the Grounded Theory, with data collected between February and March 2023 from nine postpartum women, six partners, and six nurses through semi-structured interviews, which were recorded, transcribed, and analyzed according to a theoretical methodological framework. **Results:** postpartum women and their partners described the postpartum period as the realization of their dream of having a child, but sometimes accompanied by suffering, difficulties, challenges, and emotional instability, in which health care is directly linked to the care of the newborn, leaving the needs of the woman/mother and father/partner unattended. **Conclusion:** improving prenatal, childbirth, and postpartum care is necessary to identify the needs, difficulties, and strengths of women and their partners. To this end, health professionals need to base their care on a comprehensive, humanized, and ethical approach that is committed to best practices.

Descriptors: Postpartum Period; Nursing; Women's Health; Paternity; Parent-Child Relations.

INTRODUCTION

The postpartum period begins immediately after delivery and lasts, on average, six weeks, divided into three periods:

1. Immediate, which comprises the period between the first and tenth day after delivery;
2. Late, from the eleventh to the forty-fifth day; and
3. Remote, after the forty-fifth day.

Although the literature defines the number of days for each period, in clinical practice, the demarcation of these periods is imprecise, depending on the individuality of each woman, since numerous changes and adaptations occur simultaneously during the postpartum period[1].

In 2016, the Brazilian Ministry of Health launched the Partners' Prenatal Guide, which addresses issues related to fatherhood and gender. It highlights the need to reflect on the partner's role in caring for postpartum women and newborns, helping with household chores, and promoting dialogue within the family[2].

In order to strengthen partners' participation in the immediate postpartum period, in Brazil, the Law 13,257/2016, which provides for public policies for early childhood, addresses, in Article 38, the extension of paternity leave to 15 days, which contributes to strengthening family ties and promotes improvements in postpartum care[3].

It is important to highlight that paternal care extends beyond this period of leave, as the postpartum period brings significant changes to the family structure and the physical and psychological conditions of those involved, underscoring the importance of the partner's support and availability during this time[4].

In view of this, there is a clear need to care for and welcome not only women, whether pregnant, in labor, or postpartum, and their children, but also to include their partners so that both can share their perceptions, experiences, feelings, and difficulties, thereby helping to build their identities and develop nursing actions that consider them during the postpartum period[4-6].

Given that the postpartum period is an event that involves various family arrangements, the focus of care should go beyond the mother-baby dyad and attention restricted to the newborn, including attention to the partner and other family members[6,7]. Although the Brazilian Ministry of Health recognizes the need for this expanded care, health services are still limited to postpartum women and their children. Furthermore, there is still little scientific evidence evaluating the partner's role in care during the postpartum period, and studies addressing this issue are needed.

In light of the above, the objectives of this study were to reveal the perceptions and experiences of postpartum women and their partners during the postpartum period and to analyze the actions developed by nurses in caring for this population.

METHODS

This qualitative study was conducted between February and March 2023 in the Primary Health Care system of a municipality in the northwest of Rio Grande do Sul, Brazil.

The methodological framework was based on the Grounded Theory (GT), which has three main methodological strands: classic[3], *Straussian,* and constructivist[8].

Grounded Theory (GT) enables reciprocal construction through interactions, experiences, and the environment between the research subject and the researcher. It is a qualitative, systematic, flexible research method with guidelines, phases, and principles. It focuses on the data attributed by participants to the topic being researched, which must be contextualized, thus allowing new data to be added according to the research needs[8].

The theoretical sampling is based on the selection of participants. It is the result of the simultaneous collection, coding, and analysis stages to identify what new data will be collected. In this study, sampling was implemented in all variants of the GT which is considered a key procedure in its construction. Thus, the sample consisted of nine postpartum women, six partners, and six nurses, totaling 21 participants.

The inclusion criteria applied to the selection of postpartum women and their partners were: being in the postpartum period (immediate, late, or remote) or having experienced it in the last 12 months, being over 18 years of age, and being linked to Family Health Strategy (ESF, Portuguese acronym) teams in a municipality in the northwest of Rio Grande do Sul, Brazil. For nurses, the criteria were: age ≥ 18 years, having provided or currently providing direct care to postpartum women and/or their partners, and being employed by the municipality's Primary Health Care system. Postpartum women and partners who had abortions, stillbirths, and/or neonatal deaths were excluded, as were professionals who were on vacation and/or leave at the time of data collection.

Participants were selected based on convenience[9,10]. Regarding postpartum women and their partners, the ESF teams in the municipality identified individuals who met the study inclusion criteria, using a list that included their names, addresses, telephone numbers, and the postpartum period in which they were. The postpartum women were contacted by one of the researchers by telephone, who introduced herself, explained the purpose of the study, and scheduled the interview at the postpartum women's homes, according to their availability.

In this way, the first sample group was formed with nine postpartum women and six partners. The dialogue with this group began with a semi-structured interview containing open-ended and sociodemographic questions. The guiding question was: How was or has been your experience of the postpartum period? This was followed by the following questions: What are the most significant difficulties and challenges during the postpartum period? How was the health care you received during this period, and who provided it? The interviews lasted an average of 20 minutes, and all were recorded with the participants' consent and subsequently transcribed, totaling 23 pages of empirical material.

Based on the data analysis and participants' responses coding in the first sample group, new data emerged, requiring the construction of a new sample group composed of health professionals and nurses who are members of the ESF teams. The professionals were contacted by telephone, and an interview was scheduled at their workplace, according to their availability. The guiding questions related to the object of study were: How is health care provided to postpartum women and their partners? What health care is provided to postpartum women and their partners? The interviews were recorded, with an average duration of 15 minutes, and subsequently transcribed, totaling eight pages of empirical material.

Data collection was completed once theoretical saturation was achieved, in other words, hen participants' statements became repetitive, with no new findings related to the phenomenon[8]. No further interviews were deemed necessary.

The coding process followed Charmaz's constructivist approach[8]. Data collection and analysis occurred simultaneously, guided by comparative analysis and categorization of findings, following initial coding and focused coding steps[8].

Data were fragmented and analyzed during initial coding to be transformed into codes. This coding stage can be performed word by word, line by line, or incident by incident. In the initial coding, the codes are defined as provisional, allowing the researcher to expand the analytical possibilities. Subsequently, as the coding and categorization of the findings progress, the provisional codes are replaced by permanent codes[8].

Focused coding enables the separation, classification, and synthesis of a larger number of more selective and conceptual codes[8]. It is worth remembering that, for each sample group, the initial and focused coding stages are carried out according to the construc-

tivist methodology[3]. Thus, the study categories were generated based on the frequency and prominence of the concepts.

The theoretical sampling process helped to develop the central category, which consists of three subcategories.

It is worth noting that, according to the GT, researchers can rely on tools that help to obtain the study phenomenon[8]. In this case, the preparation of memos can contribute significantly to a better understanding of the findings and clarity of the steps and processes to be achieved/followed.

To ensure anonymity, study participants were assigned an alphanumeric code. Postpartum women were designated by the codes Post 1, Post 2, ..., Post 9; partners by the codes Part 1, Part 2, ..., Part 6; nurses by the codes Nurs 1, Nurs 2, ..., Nurs 6, according to the sequence of interviews.

Ethical aspects of the research were observed in accordance with Resolutions No. 466/2012 of December 12, 2012, of the National Health Council, and Resolution No. 510 of April 7, 2016[11,12]. The interviews were conducted after obtaining the participants' consent by signing a free and informed consent, which was made available in two copies, in digital and printed form, the latter being delivered to the interviewee. The project was submitted to the Research Ethics Committee of the Federal University of Santa Maria (CEP – UFSM) and approved under the Certificate of Ethical Review (CAAE) No. 63095722.9.0000.5346.

RESULTS

A total of twenty-one participants made up the sample, including nine postpartum women, six partners, and six nurses.

Regarding the postpartum women, eight were in the remote postpartum period (three to four months), and one was in the late postpartum period (43 days). Most of the participants (66.7%) were primiparous, with an average age of 25 years, had incomplete or complete higher education, attended between eight and fourteen consultations of prenatal care at the ESF, and mentioned that the pregnancy was planned (66.7%). The remainder (33.3%) reported that the pregnancy was neither intended nor desired.

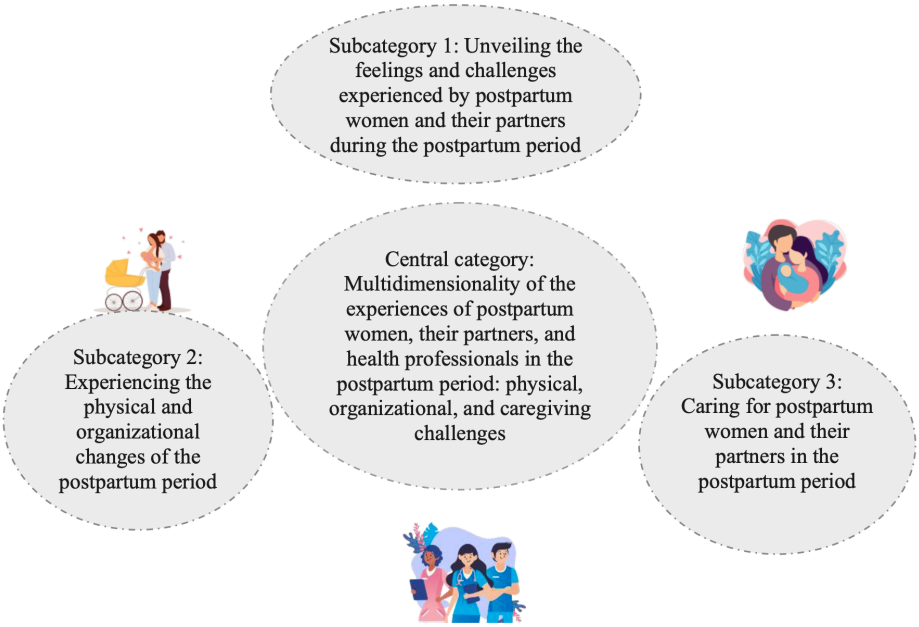
Regarding the partners, their average age was 29 years old, education levels ranged from incomplete to complete higher education, and they had low adherence to prenatal consultations, with most participating in one or two consultations. One of them was able to attend all consultations because he was self-employed. In terms of financial stability, family income, and employment, all participants were employed, and their income ranged from two to three the minimum wages.

Respecting nurses, the average age was 36 years, all had specialization, and the length of service in the municipality's ESF was 10 to 16 years.

A central category emerged from the data entitled **Multidimensionality of the experiences of postpartum women, their partners, and health professionals in the postpartum period: physical, organizational, and caregiving challenges**, with three subcategories (Figure 1), namely: Subcategory 1: Unveiling the feelings and challenges experienced by postpartum women and their partners during the postpartum period; Subcategory 2: Experiencing the physical and organizational changes of the postpartum period; Subcategory 3: Caring for postpartum women and their partners in the postpartum period. These subcategories portray the experiences, feelings, and challenges from the perspective of postpartum women and their partners, as well as nursing professionals, highlighting the importance of the postpartum period in the lives of each individual.

The subcategories found in the study are presented below.

Figure 1 - Diagram representing the central category and thematic subcategories that emerged from the interviews, Rio Grande do Sul, Brazil, 2023



Subcategory 1 - Unveiling the feelings and challenges experienced by postpartum women and their partners during the postpartum period

The first subcategory is related to perceptions that denote negative feelings experienced by postpartum women and their partners during the postpartum period, such as fear, insecurity, pressure, frustration, and sadness, as revealed in the following statements.

> *I was afraid she would turn to the side, cover her nose, and, like, stop breathing. I was scared of everything. I practically stayed awake [...] fearful of being unable to handle the responsibility of having such a small baby depending on you [...]. (Post 6)*

> *I didn't want to go out alone with her. I didn't feel safe. You always blame yourself, like, My God, what did I do? That wasn't what I had planned. I thought it would be much easier [...]. (Post 4)*

> *I feared not being a good father, but I tried my best to help, despite not knowing much about how to do so. I blame myself a little for being unable to help much [...]. (Part 1)*

> *There were days when I felt sad to see her unhappy, because on some days it seemed like it wasn't what she wanted, and then she blamed me because I wanted a child more than she did. (Part 4)*

The challenges experienced by partners and postpartum women during this phase address everyday problems in the postpartum period. For partners, the challenge was participating in care, as they did not feel included, and because the husband-wife relationship was damaged by distance. For postpartum women, the challenges were breastfeeding, giving themselves to the demands of caring for the newborn, and the lack of information about the challenges and difficulties faced in the postpartum period. The following statements present the specific problems faced by postpartum women in relation to breastfeeding: nipple fissures, incorrect latching, and weight loss in the newborn.

> *The challenge was between my wife and me, until we got back on the same page to take care of the baby together. At first, I felt a little left out. I didn't know how to help much. She was with the baby 24 hours a day, and when she wasn't, my mother-in-law was, and that created some distance in our relationship. (Part 3)*

> *The biggest challenge was breastfeeding and donating milk. You give more than you can. I can't even explain it. My milk dried up, and that frustrated me a lot because I wanted to breastfeed and couldn't. I was very hard on myself. I didn't feel like I was enough for her. It was my milk that was going to sustain her. I knew how important it was to breastfeed. I had a lot of cracks. She couldn't latch on. She started losing weight. I had to give up and switch to formula. (Post 4)*

> *No one prepares us. No one tells you during pregnancy what the postpartum period is like. We imagine it to be the best phase, because your greatest dream is born, but in reality, it's not quite like that. No one guided me on this issue and told me it would be so difficult. (Post 5)*

Subcategory 2 - Experiencing the physical and organizational changes of the postpartum period

The second subcategory concerns postpartum women's perceptions of hormonal, physical, and emotional changes, changes in self-perception and body image, as well as the organizational restructuring experienced by them and their partners in the postpartum period, as mentioned in the statements of postpartum women below.

> *The hard part is you. I think that if we accept ourselves. Men don't change. It's not their bodies that change. We look at things on Instagram and Facebook and think, "My God, how did she manage to get back in shape so quickly? She has a beautiful body, and I can't". (Post 2)*

> *I looked at myself in the mirror, and it seemed like I wasn't me anymore. (Post 3)*

> *My body is different, with stretch marks and cellulite; my breasts are not as beautiful as they used to be. (Post 4)*

Other aspects addressed in the participants' perceptions were related to changes in routine, family reorganization, and finances.

Women experience a series of changes during the postpartum period, ranging from reduced hours of rest and sleep to reduced autonomy due to their exclusive dedication to the demands and care of the baby. The mother, who is the primary caregiver, gives up habits and customs, such as self-care, physical activity, and leisure, to care for her child.

> *The difficult part is reorganizing your routine with a baby at home. Things are no longer on your schedule, but on your baby's schedule. You no longer have your freedom or your home. (Post 2)*

> *It wasn't easy. Everything changes completely. It feels like you're not yourself anymore; it feels like your life isn't yours anymore. It's crazy. It feels like you're living as if you were riding a roller coaster. (Post 4)*

For partners, it became clear that there was a need to adjust spending forecasts for the postpartum period.

> *The money issue was also a problem. We spent way more than we thought we would. (Part 2)*

Subcategory 3 - Caring for postpartum women and their partners in the postpartum period

The third subcategory addresses issues related to health care received by postpartum women and their partners, provided by nurses and other health team members during the postpartum period.

Regarding the care provided by nurses in the ESF, the participants reported that they did not receive guidance on self-care during the postpartum period, but only on care for the newborn, such as breastfeeding, the baby's sleep routine, bonding, and adaptation.

> *The nurse at the clinic talked to me during my baby's first appointment about how to care for her, how breastfeeding was going, her sleep, bonding, and adaptation. I also had the stitches removed, but they didn't ask me to do much, just what was necessary for the baby. (Post 5)*

The participants did not mention home visits by health professionals to postpartum women; on the contrary, they indicated that they voluntarily sought initial care through the ESF.

> *I went to the clinic after 40 days to start using birth control. (Post 5)*

In the partners' statements of postpartum women, it was evident that most did not attend prenatal care due to work, but those who did attend reported that the professionals focused on care and guidance for the pregnant woman, postpartum woman, and child.

> *I only went to one appointment with her when she was pregnant. (Part 3)*

> *The nurse focused on answering my wife, so I asked again because I also wanted to know the answers. (Part 4)*

> *I couldn't go to any appointments, I had to work, I couldn't miss work, I would have been docked pay. (Part 6)*

In turn, nurses reported that care provided to postpartum women and their partners begins in the prenatal period through routine consultations and that it is through these consultations that bonds are formed.

> *This care does not begin in the postpartum period, but rather during prenatal care. There is a whole process of prenatal monitoring, which consists of routine appointments, and this continues during the postpartum period. I advise them to come to the unit as soon as they have their baby and are discharged from the hospital. There is no schedule for postpartum consultations; I see them when they come for vaccinations, the heel prick test, removal of stitches, or childcare consultations. Partners are rarely involved; few participate [...]. (Nurs 1)*

> *The postpartum period ends with more attention being paid to the child in childcare. (Nurs 2)*

> *For postpartum women, we monitor them and provide all prenatal care, so we establish a bond [...]. (Nurs 5)*

The professionals' statements emphasize care and monitoring during the postpartum period, focusing on the mother-baby dyad and highlighting that there are no specific activities for fathers/partners in prenatal, postpartum, and childcare consultations.

DISCUSSION

The main category, "Multidimensionality of the experiences of postpartum women, their partners, and health professionals in the postpartum period: physical, organizational, and caregiving challenges," reveals that participants develop a nuanced perception of this important period of their lives, involving multiple dimensions.

The subcategory "Unveiling the feelings and challenges experienced by postpartum women and their partners during the postpartum period" portrays the fear and insecurity reported in the statements of postpartum women and their partners regarding newborn care. Furthermore, responsibility for caring for the baby is placed almost exclusively on the mother, which leads to pressure to be a good mother.

The postpartum period begins with the birth of a child, a time when women and their partners/fathers start to face new experiences, responsibilities, and difficulties. During this process, women undergo significant hormonal, physical, and emotional changes in their self-perception and body image[13-15]. These changes can manifest themselves through pain/discomfort, anxiety/fears, insecurities/worries, low self-esteem, and difficulty relating to your support network, partner, family, and child[13,14].

Feelings of sadness were reported by the postpartum women in this study due to their fear of not being a good mother, of not being able to assume this responsibility in accordance with their expectations. The self-imposed pressure on postpartum women to "be a good mother" can trigger a negative experience when their expectations about motherhood are not met, which can give rise to negative feelings in the face of so many demands[16].

Still regarding the challenges faced by postpartum women in this study, maintaining Exclusive Breastfeeding during the first six months of life was cited as a problem. Although it is well established that breastfeeding is an important factor in protecting the health of both mother and baby, as it reduces infant morbidity and mortality[15], women find it challenging to maintain this practice, and this cannot be overlooked in the professional approach, since the barriers faced are unique and require an individualized approach.

Despite mothers' knowledge about the benefits of breastfeeding, weaning rates before six months are high[17], corroborating the findings of this study, in which the vast majority breastfed for three to four months. It is necessary for nurses working in the care of postpartum women to promote moments of health education and listening[17].

The subcategory "Experiencing the physical and organizational changes of the postpartum period" reveals intrinsic issues about body image and family and social arrangements that interfere with

daily routines. At this point, there is a need for family and social reorganization due to the increased responsibility of caring for the newborn, which takes precedence over the woman's own needs, requiring adaptation to a new role and making the postpartum experience a complex process[18].

Among the challenges of fatherhood mentioned by the participants in this study, the change in the husband-wife relationship, perceived as a result of distancing, stood out. The mother plays the role of mediator in this dynamic, considering that the man may experience feelings of jealousy due to the greater attention devoted to the child. Thus, mutual support and approval facilitate paternal closeness. Amid the uncertainties faced by the couple, this relationship strengthening can bring comprehensive benefits to the father-mother-child triad, promoting improved coexistence, strengthening the marital union, and consolidating emotional bonds[5].

Another challenge listed by the partners in this study was the difficulty of participating in the care of their children because they did not feel included. It can be said that the father figure is still imbued with a historical weight based on past family experiences and accumulated social interactions. Identifying these elements and overcoming inherited stigmas contributes significantly to family adherence and engagement[6,7]. The direct participation of men is a fundamental mechanism, as it improves marital relationships and strengthens the emotional bond with the child.

Regarding partners' non-attendance at prenatal, postpartum, and childcare consultations, the findings of this study show that partners/fathers were absent or uninvolved, a situation justified by lack of time, inflexible working hours, or feeling unwelcome. The absence of partners due to difficulties in reconciling work schedules with appointment schedules was found in other studies[19-21]. However, the proportion of participation varies considerably. In the present study, only one partner was present. In contrast, another study found that 87.2% of men had participated in some prenatal consultation, with half (50.3%) accompanying the pregnant woman to all consultations and about 13% not attending any consultation. The main obstacles to this were the inability to miss work (80.6%) and inconvenient schedules (15.1%)[21].

It is worth remembering that male involvement can manifest itself in various forms of participation and assistance, ranging from accompanying women to prenatal appointments and providing care to sharing domestic responsibilities. This more comprehensive involvement stems from a greater understanding on the part of men, combined with encouragement from women, contributing to maintaining marital harmony.

The presence of men is essential for preserving women's health during the postpartum period. Their participation in educational practices, prenatal care, during childbirth, and in maternal and neonatal care during the postpartum period is significantly important for maternal homeostasis[4-6].

A longitudinal study conducted in the United States of America (USA) with 95 African-American pregnant women investigated how partner involvement during pregnancy relates to maternal depressive symptoms and psychological well-being. The findings showed that 80% of pregnant women reported significant paternal involvement, and these women had lower levels of prenatal depression and greater emotional well-being compared to those without such support. The authors recommend that nurses and health professionals encourage fathers to participate in consultations, ask questions, and become actively involved in the prenatal process[22].

In addition, the participation of fathers/partners in family planning strengthens family ties, promotes security and support for women, and is encouraged in Brazil by the National Policy for Comprehensive Men's Health Care[20].

In this thematic category concerning perceptions about the changes faced during the postpartum period, there is a dimension related to women's perceptions of their body image, which led to weakened self-esteem, emotional distress, and difficulty accepting their new bodies.

A woman's body image suffers a considerable impact during the postpartum period due to aesthetic changes associated with pregnancy, which increase the risk of developing stretch marks, edema, geloid fibroedema (cellulite), localized lipodystrophy, melasma, acne, diastasis, and flaccidity. Such physical changes can lead to reduced self-esteem and exacerbated emotional sensitivity in women, increasing the risk of emotional crises arising from the need to adapt and manage these conflicts appropriately[23].

During pregnancy and the postpartum period, the female body deviates from the ideal standard imposed by society, negatively affecting women's self-image and self-perception in a society where comparisons between women trigger dissatisfaction with the physical body, affecting emotional state and self-esteem[15]. Social demands for rapid recovery of a "thin" or flawless body are widely propagated on digital platforms, especially by influencers who promote strict diets, strenuous exercise regimens, and the use of topical slimming products. This idealized body image, often disconnected from reality, becomes an object of desire among women and can precipitate the onset of psychological and emotional disorders[24].

The subcategory "Caring for postpartum women and their partners in the postpartum period" portrays the fragility of this process at such a unique moment in the lives of those who experience it, focusing only on newborn care and failing to address the stigmas and anxieties of those involved.

An important figure in the process of caring for the family unit during prenatal care, postpartum care, and childcare is the nurse. Nurses act as facilitators in the process, clarifying doubts, establishing informative dialogues, and providing guidance to both mothers and fathers on necessary care, emphasizing paternal rights in active participation in prenatal care, childbirth, and postpartum care. In addition, the nurse also promotes the recommended tests for each stage (rapid tests for infectious diseases and routine tests for diseases that can harm the child's development and the mother's health), vaccinating the mother and newborn, and conducting the consultations recommended by the Brazilian Ministry of Health[2,25].

The user embracement should be provided by the nurse to

the woman/mother in a humane manner, with a holistic view, not considering pregnancy solely as a natural reproductive process. The nurse should understand this woman as a whole, perceiving her anxieties and desires, promoting strengthening the bond and consequent adherence to consultations and prenatal, delivery, and postpartum care[17].

A study indicates that nursing care focuses primarily on the newborn, with childcare overlapping postpartum consultations, thus leading to a lack of attention to the needs of women/mothers and fathers/partners during this period[13,17,26], which is consistent with the findings of the present study. This context places mothers, in their capacity as women, in a vulnerable situation, since their individual characteristics as people may go unnoticed and, therefore, their needs may be ignored and unmet.

Regarding the care provided by nurses and other members of the ESF teams, the father/partner was not included in the care process related to prenatal, postpartum, and childcare. A qualitative study with first-time fathers revealed that, although they wanted to be an integral part of the process, they were often excluded from discussions, decision-making, and care. They were described as "present but invisible," feeling emotionally unprepared during pregnancy, including in cases of pregnancy loss[27]. This is not only a Brazilian reality or one found in this study. A scoping review[28] based on 62 studies (including countries such as Sweden, Australia, Canada, the United Kingdom, and the United States of America) showed that fathers often feel excluded in prenatal clinics, perceiving professionals and the hospital environment as focused only on women. Measures of emotional disconnection, lack of communication, and lack of recognition of fathers were recurrent in the studies analyzed[28].

In the present study, the first postpartum care was initiated by the postpartum women themselves, that is, they sought health services for prenatal consultations, vaccination, newborn screening, and other newborn care and/or for the removal of stitches from the cesarean section, showing that nurses working in the setting of the present study and their team did not perform home visits.

A national study conducted in Brazil showed that, while prenatal care is well scheduled and systematized, postpartum care depends on the woman's initiative. There is no guarantee of consultation or home visits; newborn care (e.g., heel prick test, vaccination) may also be left to those who spontaneously seek the service[29]. This reactive model highlights gaps in the transition to the postpartum period, with little coordination between the stages[30].

Although the methodology adopted — anchored in the Grounded Theory — allows for the theoretical construction of the sample and data saturation as criteria for closing data collection, the initial use of convenience sampling, with participants indicated by Family Health Strategy teams, stands out as a limitation. This process may have restricted the diversity of experiences, favoring subjects with greater ties to health services and possibly excluding more critical experiences or those further away from institutional care.

Furthermore, the study was conducted in a single municipality in the northwest of Rio Grande do Sul, which may limit the findings transferability to other regional and cultural contexts. Thus, caution is recommended when generalizing the results, since perceptions and practices surrounding postpartum care and partner involvement may vary according to the socioeconomic, geographic, and organizational context of health services.

In view of the above, improvements in prenatal, childbirth, and postpartum care are necessary, given that needs, difficulties, and potentialities were identified in the statements of the participants in this study related to the health care provided to postpartum women, fathers/partners, and their children. Thus, we recommend the development and implementation of strategic planning to help address the challenges experienced by postpartum women and their partners, based on a humanized, ethical, and committed approach focused on disease prevention, health promotion, and comprehensive care for individuals, so that best practices are adopted and applied in this care setting.

CONCLUSION

In the perception of postpartum women and their partners, the postpartum period is idealized as the fulfillment of the dream that comes with the birth of a child. However, this phase also involves navigating new experiences permeated by responsibilities; family, personal, and professional reorganization; difficulties; challenges; emotional instability; and negative feelings, such as fear, insecurity, self-imposed pressure, frustration, and sadness.

The care provided by health professionals, especially nurses, still presents limitations in ensuring a smooth transition from prenatal to postpartum care, which is poorly connected and systematized. Limitations are also found regarding the guidance offered to postpartum women and their partners, since care is centered primarily on the mother-baby dyad and leaves fathers/partners aside, even though they are essential, as they act as a support network, providing security and emotional well-being.

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Conflict of interests

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