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Factors associated with adherence to postpartum consultations in a capital city in Northern Brazil

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ABSTRACT

Objectives: to estimate and analyze factors related to attendance at postpartum consultations among women assisted by Family Health Strategy teams within a capital city in Northern Brazil. **Methods:** analytical cross-sectional study conducted in Boa Vista, Roraima (Northern Brazil), through structured face-to-face interviews guided by forms containing questions addressing individual characteristics, prenatal, and postpartum care. Descriptive analysis, Pearson's chi-square test, and simple and multiple logistic regressions were performed. **Results:** a total of 363 women participated, 77.6% of whom attended postpartum consultations. Higher educational level (p = 0.001), paid employment (p = 0.002), and receiving guidance at hospital discharge regarding the importance of primary care follow-up after childbirth (p < 0.001) were associated with a greater likelihood of attending postpartum consultations. **Conclusions:** extrinsic factors are associated with increased adherence to postpartum consultations. Since these are modifiable, they may guide the development of public policies aimed at promoting continuity of care during the puerperium.

Descriptors: Postpartum Period; Women`s Health; Primary Health Care; Continuity of Patient Care; Delivery of Health Care.

INTRODUCTION

The puerperium represents a stage in the gravidic cycle marked by significant physical and emotional changes for women, requiring special attention due to greater vulnerability to complications[1-10] and concerns[11] that health professionals must address. Care and support must prove adequate to ensure well-being for the mother-newborn dyad while reducing risks and complications such as hemorrhage, infections, breastfeeding-related mammary issues, among others[12,13].

Given vulnerabilities experienced during this period, the Brazilian Ministry of Health established the care protocol named "First Week of Comprehensive Health"[14,15], which seeks to preserve and strengthen maternal-infant health through promotion of comprehensive, multiprofessional care for women and newborns during the first week postpartum. In addition to actions instructing women on postpartum care, guidance occurs regarding neonatal screening tests, encouragement and support for breastfeeding, vaccine card monitoring, scheduling of postpartum consultations, and reproductive planning[16].

In this context, Primary Health Care plays a fundamental role in coordinating and organizing assistance to women throughout the gravidic-postpartum cycle. The postpartum consultation, an integral part of this care, aims to ensure continuous care addressing actual health needs during the puerperium while providing opportunities for health professionals to strengthen bonds with postpartum women.

However, despite these benefits, studies have evidenced low prevalence of postpartum consultations in Brazil[17,18].

Moreover, studies indicate that Black and Indigenous race/color, residence in northern and northeastern Brazil, low education level, dissatisfaction with pregnancy, low income, and lack of awareness regarding consultation relevance influence adherence to postpartum consultations[15,17,19].

This scenario may worsen in states characterized by health service fragility and constant migratory movements, which significantly overload local health systems, reduce human resources, and weaken referral and counter-referral systems. These circumstances combine with access difficulties to Indigenous populations and more distant regions from the capital, configuring additional barriers to seeking and accessing health services[20].

Considering that postpartum consultations constitute an important strategy to reduce maternal morbidity and mortality, as well as unfavorable characteristics present in Northern Brazil regarding health service seeking and access, this study aimed to identify and analyze factors associated with women's adherence to postpartum consultations conducted by Family Health Strategy (FHS) teams in a capital city in Northern Brazil.

METHODS

This research forms part of the matrix project titled "Prenatal care and continuity of care during the puerperium, Boa Vista, Roraima". The present analysis constitutes a quantitative, cross-sectional, and analytical study conducted from January to August 2023 in the municipality of Boa Vista, capital of the state of Roraima, located in Northern Brazil, with a territorial area of 5,687 km^2 and a population of approximately 413,486 inhabitants[21].

The study involved postpartum women residing in Boa Vista, attended by Family Health Strategy (FHS) teams distributed across the nine macro-areas. Sample size calculation considered total live births in Boa Vista in 2021 from the National Live Births Information System (Portuguese acronym: Sistema Nacional de Nascidos Vivos – SINASC) data, reflecting the approximate number of pregnant women in the territory. Based on this total, the pregnant population was estimated at 8,195. Additionally, the coverage prevalence of live births with six or more prenatal consultations (49.7%), a 5% margin of error, and 95% confidence interval (95%CI) yielded a sample of 353 women. EPI-Info software (version 7.0, Centers for Disease Control and Prevention – CDC, United States) and Excel® (version 2021, Microsoft Corporation, United States) supported sample size calculation.

An additional 20% compensated for potential losses or refusals, totaling 363 postpartum women. Accounting for variations in live-birth populations across health services, the sample underwent stratification based on approximate birth estimates per macro-area.

Inclusion criteria comprised age 18 years or older, residence in the Boa Vista municipality, and attendance at Basic Health Units in this municipality. Exclusion criteria encompassed migrant postpartum women, Indigenous women, and those physically or psychically unable to respond to research questions.

Data collection occurred at FHS units through face-to-face structured interviews with women, using forms addressing sociodemographic characteristics as well as prenatal and postpartum care topics. Prenatal cards provided supplementary data when available. Previously trained interviewers approached women in waiting rooms to present study invitations and verify inclusion criteria. For consenting participants, researchers explained study objectives and obtained signatures on the Informed Consent.

The primary outcome measured adherence to postpartum consultation (no, yes). Explanatory variables included maternal age; self-reported skin color; maternal education; marital status; paid employment; family income; parity; gestation type; satisfaction with prenatal care; adequacy of prenatal care; and receipt of guidance at the maternity unit to return to the FHS unit for postpartum consultation. Prenatal care adequacy required initiation by the 12th gestational week and a minimum of six consultations during pregnancy.

Descriptive analysis (absolute and relative frequencies) preceded Pearson's chi-square test and simple and multiple logistic regressions, with $p < 0.05$ deemed significant. Results appear as crude odds ratios (ORc) and adjusted odds ratios (ORa), with respective confidence intervals.

Analyses utilized Statistical Package for Social Science for Windows – SPSS (version 21.0, International Business Machines Corporation – IBM, United States).

The matrix project received approval from the Research Ethics Committee of the Federal University of Roraima. Certificate of Presentation for Ethical Consideration (CAAE) number 64542122.8.0000.5302.

RESULTS

Most postpartum women presented age between 20 and 34 years (81.3%), 74.4% self-reported brown skin color, 75.5% lived with a partner during pregnancy, 64.0% completed high school, 39.4% engaged in paid work, 62.2% reported mean monthly income of two minimum wages (reference minimum wage value in May 2023 = $1,320.00), 65.0% were multiparous, 98.9% experienced singleton gestation, and 75.9% reported satisfaction with prenatal care (Table 1).

Postpartum consultation adherence rate reached 77.6% (n = 281), with higher proportions among women with higher schooling (84.3%), who engaged in paid activity (86.0%), and who received guidance during maternity hospitalization to return to the FHS unit for postpartum consultation (85.5%), as observed in Table 2.

Univariate analysis investigating factors associated with postpartum consultation adherence indicated that women with higher schooling levels, paid work, and guidance to return to the FHS unit for postpartum consultation exhibited greater chances of attending postpartum consultations (Table 3). Multiple analysis revealed that women with complete high school (ORa = 3.70; 95%CI 1.62 – 8.46)

Table 1 - Distribution of sociodemographic characteristics and prenatal and postpartum care among participants (n = 363), Family Health Strategy, Boa Vista, Roraima, 2023

Characteristics	n	%
Age		
≤ 19 years old	31	8.5
20-34 years old	295	81.3
≥ 35 years	37	10.2
Skin color		
Brown	270	74.4
Black	42	11.6
White	44	12.1
Asian	7	1.9
Marital status		
Without a partner	89	24.5
With a partner	274	75.5
Schooling		
Incomplete elementary school	32	8.8
Complete elementary school	48	13.2
Complete high school	232	63.9
Higher education or above	51	14.1
Paid work		
No	220	60.6
Yes	143	39.4
Renda familiar (n = 360)*		
≤ 1 minimum wage	107	29.7
2 minimum wages	224	62.2
≥ 3 minimum wages	29	8.1
Parity		
Primiparous	127	35.0
Multiparous	236	65.0
Gestation type (n = 361)*		
Singleton	357	98.9
Multiple	4	1.1
Satisfaction with prenatal care (n = 352)*		
Not satisfied	85	24.1
Satisfied	267	75.9
Adequacy of prenatal care (n = 300)*		
Inadequate	74	24.6
Adequate**	226	75.4
Guided at maternity to return to Family Health Strategy unit for postpartum consultation (n = 362)*		
No	140	38.7
Yes	222	61.3

Note: * Difference in number of participants due to missing data; ** Adequate prenatal care – follow-up initiation occurred by the 12th gestational week and minimum of six prenatal consultations performed.

Table 2 - Sociodemographic characteristics and prenatal care and postpartum care of women attended by Family Health Strategy (n = 281), according to postpartum consultation adherence, Boa Vista, Roraima, 2023

Characteristics	Adherence to postpartum consultation		*p*-value*
	n	%	
Age			
≤ 19 years old	20	64.5	0.186
20-34 years old	232	78.9	
≥ 35 years old	29	78.4	
Skin color			
Brown	202	74.8	0.156
Black	34	82.9	
White	39	88.6	
Asian	6	85.7	
Marital status			
Without a partner	74	83.1	0.187
With a partner	207	75.8	
Schooling			
Incomplete elementary school	16	51.6	0.001
Complete elementary school	34	70.8	
Complete high school	188	81.0	
Higher education or above	43	84.3	
Paid work			
No	158	72.1	0.002
Yes	123	86.0	
Household income (n = 279)**			
≤ 1 minimum wage	76	71.7	0.148
2 minimum wages	178	79.5	
≥ minimum wages	25	86.2	
Parity			
Primiparous	100	78.7	0.708
Multiparous	181	77.0	
Satisfaction with prenatal care (n = 270)**			
Not satisfied	68	81.0	0.315
Satisfied	202	75.7	
Adequacy of prenatal care (n = 232)**			
Inadequate	55	74.3	0.476
Adequate***	177	78.3	
Guided at maternity to return to the Family Health Strategy unit for postpartum consultation			
No	92	65.7	< 0.001
Yes	189	85.5	

Note: *Pearson's χ^2 test; **Difference in number of participants due to missing data; ***Adequate prenatal care – follow-up initiation occurred by the 12th gestational week, and minimum of six prenatal consultations performed.

Table 3 - Sociodemographic factors and prenatal care and postpartum care among women attended by Family Health Strategy associated with postpartum consultation attendance, Boa Vista, Roraima, 2023

Characteristics	Adherence to postpartum consultation			
	RCb[A]	95%CI[B]	RCa[C]	95%CI[B]
Age				
≤ 19 years old	0.50	0.71 – 1.47		
20-34 years old	1.03	0.45 – 2.37		
≥ 35 years old	1.00			
Skin color				
White	1.00			
Brown	0.38	0.14 – 1.00		
Black	0.62	0.18 – 2.14		
Asian	0.77	0.08 – 7.77		
Marital status				
Without a partner	1.00			
With a partner	0.64	0.34 – 1.18		
Schooling				
Incomplete elementary school	1.00			
Complete elementary school	2.28	0.89 – 5.83	2.45	0.91 – 6.60
Complete high school	4.01	1.84 – 8.71	3.70	1.62 – 8.46
Higher education or above	5.04	1.79 – 14.15	3.76	1.21 – 11.69
Paid work				
No	1.00			
Yes	1.37	1.36 – 4.15	2.08	1.13 – 3.85
Family income				
≤ 1 minimum wage	1.00			
2 minimum wages	1.53	0.90 – 2.60		
≥ 3 minimum wages or more	2.47	0.79 – 7.69		
Primiparous				
No	1.00			
Yes	1.10	0.65 – 1.86		
Satisfaction with prenatal care[D]				
Not satisfied	1.00			
Satisfied	1.37	0.74 – 2.52		
Adequacy of prenatal care				
Inadequate	1.00			
Adequate	1.25	0.68 – 2.30		
Guided at maternity to return to Family Health Strategy unit for postpartum consultation				
No	1.00			
Yes	3.08	1.85 – 5.14	2.49	1.46 – 4.26

Note: [A]ORc: Crude Odds Ratio; [B]95%CI: 95% Confidence Interval; [C]ORa: Adjusted Odds Ratio; [D]Adequate prenatal care – follow-up initiation occurred by the 12th gestational week and minimum of six prenatal consultations performed.

and higher education or above (ORa = 3.76; 95%CI 1.21 – 11.69), who engaged in paid activity (ORa = 2.80; 95%CI 1.13 – 3.85), and who received guidance at maternity to return to the FHS unit for postpartum consultation (ORa = 2.49; 95%CI 1.46 – 4.26) presented greater chances of attending postpartum consultations compared to those who did not attend (Table 3).

DISCUSSION

Care during the immediate puerperium is indispensable, since the gravidic-postpartum period is marked by both physical and psychological changes, and it is primarily the responsibility of primary care teams to promote actions for continuous care for postpartum women, as well as to identify and actively seek those who miss appointments[22].

The prevalence of adherence to postpartum consultation in the municipality of Boa Vista reached 77.4%, differing from findings reported in the few epidemiological studies on this topic in Brazil[23,24]. One of the lowest adherence proportions was identified in a study carried out in Paraná (56.9%)[23], which may be explained by a lack of scheduled consultations, difficult access, and insufficient guidance. In turn, these factors may relate to challenges faced by FHS teams, such as limited provision of continuing education for health professionals, reduced human resources, uncovered micro-areas, high patient flow, and work overload, which together weaken care and assistance for users of the public health system[24,25].

Although the present study demonstrated satisfactory coverage of postpartum consultation in the study territory, it is important to highlight existing weaknesses in Primary Health Care (PHC) services in Roraima, including flaws in referral and counter-referral systems and limitations in timely service provision for users. These challenges resemble those reported in other regions of Brazil, where the main reasons for women missing postpartum consultations include lack of guidance, access barriers, and either absence of scheduling or scheduling outside the recommended period[23,25]. As a result, the population shows limited awareness regarding appropriate use of health services, and health teams experience difficulties in monitoring women's actual needs, which compromises early detection of potential complications and continuity of care.

Regarding associated factors, this study identified that socioeconomic characteristics and having received guidance during maternity hospitalization contributed to adherence to postpartum consultation.

As maternal education increased, chances of attending postpartum consultation also increased ($p = 0.001$). Similarly, the "Birth in Brazil" survey showed that lower schooling levels reduce chances of continuity of care during pregnancy and puerperium, with almost 40.0% higher likelihood of women with incomplete schooling failing to return for consultations compared with those with higher education[17]. Some studies indicate that seeking consultations in the puerperium is also related to adequacy and satisfaction with prenatal care, which directly influence scheduling and attendance at postpartum consultations[15,19,24].

Another important result in this study concerns greater chances of women engaged in paid work attending postpartum consultation ($p = 0.002$), which aligns with findings from a cohort study conducted in Rio Grande do Sul, in which 52.6% of women did not perform paid activities, a factor associated with non-adherence to postpartum consultations[26]. Likewise, the hospital-based "Birth in Brazil" survey showed that women without paid employment have a significantly lower probability of returning for continuous care[17].

In light of this evidence, it is possible to state that women who have paid work and higher schooling levels are more likely to return for postpartum consultations, as they have greater access to information and knowledge about the importance of follow-up. Another aspect to consider is that women engaged in paid work may seek health services to prevent complications, because they need to plan their return to work within the legally established timeframe for paid maternity leave.

In addition, this study identified higher chances of postpartum consultation among women who received guidance while still in the maternity unit ($p < 0.001$), corroborating a study conducted in Rio de Janeiro, which observed that 65.2% of patients had adequate prenatal care and 69.9% received information and guidance in the maternity unit to seek health services after childbirth[12]. Thus, comprehensive care for women across different levels of health care is a determinant factor for seeking postpartum consultations and reducing adverse maternal and perinatal outcomes[12,26]. Within this context, specialized outpatient care plays a crucial role in facilitating return to primary care and should provide a humanized reception and clear, essential instructions that highlight the importance of attending the first postpartum consultation[12].

Despite advances in women's health policies, there remains an urgent need to ensure comprehensive, humanized, and individualized services for women throughout the gravidic-puerperal cycle, given the weak coordination between health services when referring and counter-referring users, which compromises continuity of care.

Therefore, investment is essential in staff training through continuing education, ensuring timely access for women to health services and actions, implementing strategies for early identification and active search for pregnant and postpartum women, training involved professionals, and investing in educational practices focused on active user participation in decision-making processes[27].

Furthermore, strategies must be strengthened not only to inform women about the crucial nature of postpartum maternal care, but also to actively encourage their participation in returning for consultations. In this context, health education in primary care plays a central role, especially by prioritizing the inclusion of women with lower schooling and income. Group meetings involving comprehensive guidance and use of communication technologies become essential tools to promote effective information exchange between health professionals and users. Such strategies not only equip postpartum women with essential knowledge, but also support a confident and informed return to health services, thereby promoting a healthy transition to the postpartum period.

Finally, limitations of this study include its sample, which comprised Brazilian postpartum women assisted at FHS units, meaning that women assisted in private services, migrants, and Indigenous women were excluded; future studies with these populations are needed to identify and analyze their profiles regarding adherence to postpartum consultation. Additionally, difficulties were encountered in recruiting women in some macro-areas of the municipality due to changes in service hours during the process of expanding Primary Health Care. Moreover, data collection depended on respondents' memory and collaboration, which may have influenced estimates.

However, these limitations do not diminish the relevance of the findings, as factors that negatively influence adherence to postpartum consultation were identified, including schooling level, family income, and receipt of guidance to return to the primary care unit for scheduling and postpartum consultation.

Thus, strengthening initiatives that promote health in the continuity of postpartum care is essential, including an active search for women who miss appointments within the population assisted in PHC under the Brazilian Unified Health System. It is also important to reinforce discharge guidance provided in tertiary care, as well as communication between the three levels of care (primary, secondary, and tertiary), with the aim of positively influencing women's decisions to attend consultations and, consequently, expanding postpartum consultation coverage.

Based on the results of this research, broader discussion is expected regarding interventions in care from prenatal to the postpartum period, encouraging user participation through educational practices that raise awareness of the importance of maternal and child health care during the puerperium. In addition, future studies are needed to evaluate how adherence to consultation evolves, considering improvements implemented in health services in Boa Vista.

CONCLUSION

Evidence from this research reaffirms that women engaged in paid work and with higher schooling levels exhibit greater chances of attending postpartum consultations, possibly due to knowledge about public policies and the importance of puerperal care and needs.

Moreover, information and guidance received at the maternity unit regarding rescheduling the first postpartum consultation proved determinant for continuity of care for postpartum women. Thus, remodeling primary care team actions becomes necessary, focusing on care quality and health service efficiency, with comprehensive monitoring and care for postpartum women through promotion of planned and qualified actions that encourage both professionals to adopt better practices and users to adhere to postpartum consultations.

REFERENCES

1. Merighi MAB, Gonçalves R, Rodrigues IG. Vivenciando o período puerperal: uma abordagem compreensiva da Fenomenologia Social. Rev Bras Enferm. 2006 Dec;59(6):775–9. https://doi.org/10.1590/S0034-71672006000600010

2. Torres L, Perniciaro LMRF, Méndez I, Kruger AL, Mapeli A. Factores asociados a la retención de peso postparto en mujeres que asisten a un hospital público de la Provincia de Buenos Aires. Rev Fac Cien Med Univ Nac Cordoba. 2025 June 26;82(2):271-86. https://doi.org/10.31053/1853.0605.v82.n2.45625

3. Dennis CL, Singla DR, Brown HK, Savel K, Clark CT, Grigoriadis S, et al. Postpartum depression: a clinical review of impact and current treatment solutions. Drugs. 2024 May 30;84:645-59. https://doi.org/10.1007/s40265-024-02038-z

4. Maughan BC, Marin M, Han J, Gibbins KJ, Brixey AG, Caughey AB, et al. Venous thromboembolism during pregnancy and the postpartum period: risk factors, diagnostic testing, and treatment. Obstet Gynecol Surv. 2022 July;77(7):433-44. https://doi.org/10.1097/OGX.0000000000001043

5. Countouris M, Mahmoud Z, Cohen JB, Crousillat D, Hameed AB, Harrington CM, et al. Hypertension in Pregnancy and Postpartum: Current Standards and Opportunities to Improve Care. Circulation. 2025 Feb 18;151(7):490-507. https://doi.org/10.1161/CIRCULATIONAHA.124.073302

6. Ryan K, McGrath L, Brookfield K. Hypertension management in pregnancy. Annu Rev Med. 2024 Nov 25;76:315-26. https://doi.org/10.1146/annurev-med-050423-085626

7. American College of Obstetricians and Gynecologists (ACOG). Obesity in pregnancy: ACOG Practice Bulletin, Number 230. Obstet Gynecol. 2021 June;137(6):e128-44. https://doi.org/10.1097/AOG.0000000000004395

8. Huang S, Magny-Normilus C, McMahon E, Whittemore R. Systematic review of lifestyle interventions for gestational diabetes mellitus in pregnancy and the postpartum period. JOGNN. 2022 Mar;51(2):115-25. https://doi.org/10.1016/j.jogn.2021.10.007

9. Oliveira TA, Luzetti GGCM, Rosalém MMA, Mariani Neto C. Screening of perinatal depression using the edinburgh postpartum depression scale. Rev Bras Ginecol Obstet. 2022 Mar 4;44(5):452-7. https://doi.org/10.1055/s-0042-1743095

10. Csihi L, Ungvari GS, Caroff SN, Mann SC, Gazdag G. Catatonia during pregnancy and the postpartum period. Schizophr Res. 2022 Sep 5;263:257-64. https://doi.org/10.1016/j.schres.2022.08.003

11. Prince A, Wade J, Power ML, Gunawansa N, Cruz-Bendezú A, Schulkin J, et al. Postpartum care: Discussions and counseling for the peripartum period. J Neonatal Perinatal Med. 2023 Dec 1;16(4):657-64. https://doi.org/10.3233/NPM-230167

12. Domingues RMSM, Dias BAS, Bittencourt SDA, Dias MAB, Torres JA, Cunha EM, et al. Utilização de serviços de saúde ambulatoriais no pós-parto por puérperas e recém-nascidos: dados do estudo Nascer no Brasil. Cad. Saúde Pública. 2020 May 18;36(5):e00119519. https://doi.org/10.1590/0102-311X00119519

13. Aued GK, Santos EKA, Backes MTS, Santos DG, Kalivala KMM, Oliveira DR. Transição do cuidado à mulher no período puerperal na alta hospitalar. Esc Anna Nery. 2023 Aug 4;27:e20220396. https://doi.org/10.1590/2177-9465-EAN-2022-0396pt

14. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Agenda de compromissos para a saúde integral da criança e redução da mortalidade infantil [Internet]. Brasília (BR): Ministério da Saúde (BR); 2004 [cited 2025 Aug 30]. 80 p. Available from: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/s/saude-da-crianca/publicacoes/agenda-de-compromissos-para-a-saude-integral-da-crianca-e-reducao-da-mortalidade-infantil/

15. Lucena DBA, Guedes ATA, Cruz TMAV, Santos NCCB, Collet N, Reichert APS. Primeira semana saúde integral do recém-nascido: ações de enfermeiros da Estratégia Saúde da Família. Rev Gaúcha Enferm. 2018 Aug 2;39:e2017–0068. https://doi.org/10.1590/1983-1447.2018.2017-0068

16. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes [Internet]. Brasília: Ministério da Saúde (BR); 2011 [cited 2025 Aug 30]. 82 p. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_mulher_principios_diretrizes.pdf

17. Bittencourt SDA, Cunha EM, Domingues RMSM, Dias BAS, Dias MAB, Torres JA, et al. Nascer no Brasil: continuidade do cuidado na gestação e pós-parto à mulher e ao recém-nato. Rev Saude Publica. 2020 Nov 20;54:100. https://doi.org/10.11606/s1518-8787.2020054002021

18. Silva IN, Freitas CKAC, Lisboa AS, Cunha MLJS, Mahl C, Guimarães YDNC, et al. Assistência de enfermagem à saúde da mulher na Atenção Primária à Saúde. Enferm Foco. 2024 Mar 7;15(suppl 1):e-202410SUPL1. https://doi.org/10.21675/2357-707X.2024.v15.e-202410SUPL1

19. Corrêa MSM, Feliciano KVO, Pedrosa EN, Souza AI. Acolhimento no cuidado à saúde da mulher no puerpério. Cad Saúde Pública. 2017;33(3):e00136215. https://doi.org/10.1590/0102-311X00136215

20. Secretaria de Saúde do Estado de Roraima, Coordenadoria Geral de Vigilância em Saúde. Relatório Anual de Epidemiologia de Roraima 2021 [Internet]. Boa Vista: Secretaria de Saúde do Estado de Roraima; 2022 [cited 2025 Oct 31]. 427 p. Available from: https://vigilancia.saude.rr.gov.br/download/relatorio-epidemiologico-2021/

21. Instituto Brasileiro de Geografia e Estatística (IBGE). Projeção da população – Roraima [Internet]. Rio de Janeiro: Instituto Brasileiro de Geografia e

Estatística (IBGE); c2023 [cited 2025 Oct 31]. Available from: https://cidades.ibge.gov.br/brasil/rr/panorama

22. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Pré-natal e puerpério: atenção qualificada e humanizada [Internet]. Brasília (BR): Ministério da Saúde (BR); 2005 [cited 2025 Oct 31]. 163 p. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/manual_pre_natal_puerperio_3ed.pdf

23. Almeida BEM, Baggio MA, Contiero AP, Bif-Canonico SD, Ferrari RAP. Assistência à puérpera na atenção primária em três regionais de saúde do estado do Paraná. Revista de Enfermagem do Centro-Oeste Mineiro. 2023 Dec 7;13:e4934. http://doi.org/10.19175/recom.v13i0.4934

24. Baratieri T, Lentsck MH, Falavina LP, Soares LG, Prezotto KH, Pitilin EB. Longitudinalidade do cuidado: fatores associados à adesão à consulta puerperal segundo dados do PMAQ-AB. Cad. Saúde Pública. 2022 Mar 16;38(3):e00103221. https://doi.org/10.1590/0102-311X00103221

25. Braghetto GT, Sousa LA, Beretta D, Vendramini SHF. Dificuldades e facilidades do enfermeiro da Saúde da Família no processo de trabalho. Cad Saúde Colet. 2019 Nov 11;27(4):420-6. https://doi.org/10.1590/1414-462X201900040100

26. Gonçalves CS, Cesar JA, Marmitt LP, Gonçalves CV. Frequency and associated factors with failure to perform the puerperal consultation in a cohort study. Rev. Bras. Saúde Mater. Infant. 2019 Jan-Mar;19(1):63-70. https://doi.org/10.1590/1806-93042019000100004

27. Silva AA, Oliveira MS, Lima AKS, Silva RCL, Filguera WS, Barbosa LA. Saúde da família em Roraima: percepção e preferências dos usuários. SANARE. 2021 Dec 16;20(2):33-40. https://doi.org/10.36925/sanare.v20i2.1501

Authors' contributions – CrediT

RJSFF: conceptualization; investigation; methodology; visualization; writing – original draft and writing – review & editing.

BASD: conceptualization; data curation; formal analysis; investigation; methodology; project administration; software; supervision; visualization; writing – original draft and writing – review & editing.

MSC: conceptualization; investigation; methodology; visualization; writing – original draft and writing –- review & editing.

CFC: conceptualization; formal analysis and interpretation; investigation; methodology; writing – original draft and writing – revision & editing.

JCM: conceptualization; formal analysis and interpretation; investigation; methodology; writing – original draft and writing – review & editing.

RVC: formal analysis and interpretation; investigation; methodology; writing – original draft and writing – revision and editing.

CABT: formal analysis and interpretation; investigation; methodology; writing – original draft and writing – revision & editing.

TMACB: conceptualization; data curation; investigation; methodology; project management; supervision; visualization; writing – original draft and writing – review & editing.

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Conflict of interest

None.