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Evaluation of mental health care for postpartum women in primary care: an evaluative study

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Abstract

Introduction

Pregnancy is a phenomenon laden with emotions in a woman's life, bringing with it numerous hormonal, physical, and psychological changes, culminating in a series of transformations in her body.

Objective

To evaluate the mental health care provided by primary care professionals to women in the postpartum period.

Methods

An evaluative study of implementation analysis with a quantitative and qualitative approach, conducted through a multiple case study. Data collection involved the analysis of medical records and semi-structured interviews with 31 postpartum women and 24 healthcare professionals. In the quantitative analysis, the degree of implementation was assessed (classification: satisfactory, partial, incipient, and critical) determined by the Analysis and Judgment Matrix composed of the dimensions "management" and "execution", and their respective sub-dimensions. Qualitative analysis occurred through content analysis.

Results

Through quantitative data, an incipient degree was observed in cases 1 and 3, and a critical implementation degree in case 2. In the application criterion of the scale for postpartum depression diagnosis, all cases scored zero. Considering the content of the statements, they can be grouped into two categories: the presence of feelings of abandonment and sadness in postpartum women, and the lack of assistance from healthcare professionals to postpartum women.

Conclusion

It is concluded that women have postpartum health needs related to mental health; however, there is a lack of assistance from primary care professionals.

Keywords

Primary Health Care; Mental Health Care; Primary Care Evaluation of Mental Disorders; Postpartum Depression.

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Introduction

Pregnancy is a phenomenon laden with emotions in a woman's life, bringing numerous hormonal, physical, and psychological changes, culminating in a series of transformations in her body, leading her to start creating expectations regarding her gestation.[1]
In the postpartum period (after childbirth), there are modifications in this scenario, and these expectations give way to feelings of fear, anguish, and apprehension, as new mothers begin to fear that their desires may not be met, generating frustrations and insecurities.[2]
Among the common complications in the postpartum period, emotional changes stand out, with postpartum depression (PPD) being a relatively common condition in the first month after childbirth, with the possibility of extending for longer periods[3], and its prevalence is higher in teenage mothers, ranging from 14% to 53%, and from 6.9% to 16.7% in adult women.[1,4]
All changes that occur in the postpartum phase require special attention, as they can be even more recurrent in cases of unwanted, unplanned, and repudiated by family members pregnancies, social deprivation, or other factors capable of emotionally destabilizing the woman, along with hormonal factors.[1]
Thus, support for postpartum women becomes fundamental, from their families and the community itself, where healthcare services ensure quality assistance so that they can overcome their obstacles, as otherwise, it may result in complications that bring temporary and/or permanent consequences, and in some cases, lead to death.[2]
Therefore, motherhood and its nuances must be recognized as factors that directly impact women's mental health.[5] Thus, they require care, especially in the context of Primary Health Care (PHC), as it is the closest point of attention to this population and the care organizer, where the assistance provided positively impacts their health, such as reducing morbidity and mortality, contributing to care and the right to autonomy, making postpartum care necessary, provided it occurs in an organized, coherent, and applicable manner.[2]
Hence, it is of utmost importance that all postpartum women receive support from PHC professionals beyond their momentary physical and biological well-being but for the prevention of future complications. Another aspect that gives relevance to this study is the fact that there are few approaches focused on the professional's perspective on women in the postpartum period during care. Thus, the present study aims to evaluate the mental health care actions developed by PHC professionals for women in the postpartum period.

Methods

This is an evaluative study of the implementation analysis type[6], with a quantitative and qualitative approach, developed through a multiple-case study[7] guided by the precepts of the Standards for QUality Improvement Reporting Excellence (SQUIRE 2.0).
Three municipalities were selected, one from each state in the Southern Region of Brazil, named Case 1, Case 2, and Case 3, based on the following inclusion criteria: over 100,000 inhabitants, because most of them present favorable characteristics for health management;8 PHC coverage greater than 80%; over 80% of health teams enrolled in the National Program for Improving Access and Quality of Primary Care (Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica - PMAQ); over 80% of teams with "excellent," "very good," and "good" ratings in PMAQ. When more than one municipality met the inclusion criteria, professionals from the technical area of PHC and women's health, from the respective State Health Departments, were asked to choose the best case.
One family health team from each municipality with an "excellent" or "very good" rating in PMAQ was investigated. Informants included professionals from PHC teams and postpartum women attended by these teams. Professionals from the minimum family health team (doctor, nurse, nursing technician/assistant, and community health worker) with over one year of experience in the same workplace were selected. Professionals on vacation or on leave were excluded. Regarding postpartum women, those who had undergone at least one postpartum consultation up to 42 days and were at most six months postpartum were selected to reduce memory bias about the care received. The following were excluded: those with whom contact was not possible or who, due to some health condition, could not participate in the study. The eligible women were surveyed, and subsequent draw was conducted, interviewing participants until data saturation was reached. The study included 4 nurses (one from Case 1, one from Case 2, two from Case 3), two nursing technicians (one from Case 1, one from Case 2), 18 community health workers (six from Case 1, nine from Case 2, three from Case 3), and 31 postpartum women (ten from Case 1, eleven from Case 2, ten from Case 3).
One nursing technician from Case 3 on vacation was excluded, six postpartum women refused to participate, and contact with three postpartum women was not possible.
Data collection occurred in two stages: In the first stage, interviews were conducted with professionals and postpartum women, using a specific semi-structured script with language adaptation for each participant category. The scripts addressed questions directed at the investigation by professionals about the history of mental health problems, emotional state, family and social support during prenatal and postpartum periods, guidance on common emotional changes postpartum (directed to professionals and postpartum women), and the use of a scale for PPD diagnosis when identifying warning signs (for professionals). Interviews were scheduled with professionals at their respective workplaces, and women, after contact by phone or home visit by community health workers, chose the health unit or home for recorded interviews, which were transcribed in full. In the second

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stage, data were collected through the analysis of medical records of selected postpartum women.

For the data collection instrument, the Analysis and Judgment Matrix (AJM) was developed, guided by Program Theory[2] and validated by the consensus conference technique[9] with experts in the field and stakeholders (interested in the evaluation), including four women representatives of the women's movement, five professionals in the PHC and women's health area from the management of the states of Paraná, Santa Catarina, and Rio Grande do Sul, and three professionals with experience in PHC. The AJM was used to assess and determine the degree of implementation of postpartum care, composed of seven sub-dimensions (longitudinality; access; physical health; mental health; domestic violence; breastfeeding; and family planning), with the mental health sub-dimension analyzed in this study.

The value judgment for each criterion/indicator of the AJM was made through triangulation of different sources of evidence, assigning a score. The ratio of the sum of observed score (OS) in the sub-dimensions to the expected score (ES) determined the value judgment for the degree of implementation: DI (degree of implementation) = $(\Sigma \text{ OS} / \Sigma \text{ ES}) \times 100$. The proportions were stratified into quartiles for the classification of the Degree of Implementation, namely: satisfactory implementation (76% to 100%); partial implementation (51% to 75%); incipient implementation (26% to 50%); and critical implementation (below 26%).10

A pilot case study was conducted in a municipality that was not part of the main study.

After the implementation analysis, a categorical content analysis was conducted to understand in-depth the results of the implementation analysis. Subsequently, readings of the obtained data were performed to identify and interpret the needs, weaknesses, and potentialities of health care. The material was read, coded, enumerated, classified, and aggregated to arrive at an understanding and proceed with the interpretation and categorization of the results, considering the identification of units of interest, common aspects among them, and inferences.[11] The study was approved by the Research Ethics Committee of the Federal University of Santa Catarina (opinion No. 3.036.173/2018, CAAE: 02774918.80000.0121).

All research participants signed an Informed Consent Form, emphasizing their commitment to preserving the collected data and the identity of the participants. Thus, participants are represented by acronyms.

To preserve the participants' identity, they were coded according to the Case (Case) and the letter referring to the participant group (P - professional; W - woman) followed by the number corresponding to the interview sequence.

Results

The results demonstrate that mental health care in the postpartum period, during the evaluated period, showed incipient implementation for Cases 1 and 3, with Case 2 presenting a critical implementation degree, as it obtained a score below 26%. In the criterion/indicator "investigation of the history of complication/mental health problems during prenatal and postpartum", Case 1 had the highest score. In the criterion/indicator "guidance on common emotional changes postpartum", Cases 1 and 2 obtained a score of zero. Regarding the criterion/indicator "application of a scale for PPD diagnosis when identifying warning signs", all cases scored zero, meaning they did not meet the parameters. See Table 1.

After the implementation analysis, an in-depth interview analysis was conducted, and the emerging analytical categories refer to aspects that drew the researchers' attention regarding mental health care in the postpartum period, enabling the identification of main care gaps.

Feelings of abandonment and sadness in the postpartum period and unawareness of emotional changes

Feelings related to abandonment and sadness stand out in the interviews due to the high number of times they appear in the statements of postpartum women. In all three cases, out of the 31 interviewees, 13 reported feeling sad at least once after childbirth, where they felt the urge to cry, or cried at least once during the period.

I felt sad as soon as he came home, I don't know why, but I was always wanting to cry. (C1M4)

I've really had symptoms. It's something in the chest, you know, then I have to change my thinking, start doing something, feeling like crying. (C1M1)

While such feelings are present in the postpartum period, postpartum women lack knowledge on the subject, leading them not to seek help for this moment in their lives.

I don't know if it's postpartum depression, but I think it was because I felt like crying, chest pain, anguish, and I couldn't do anything because of the stitches, and it gave me more anguish because my mother did things, and I couldn't do it, in this case, giving her a bath, whether we like it or not, the first child, we want to do everything. And I was a bit down, sad, weepy. (C1M10)

I handled this alone, didn't talk to anyone, not even with my husband. It was painful not being able to talk, not even with the doctor, I didn't talk because I thought it was something of mine, I thought it was fussiness, some people won't understand, so you have to keep it to yourself. (C1M4)

The absence of a support network for women during the phase of emotional changes, especially due to the lack of knowledge about the processes experienced in the postpartum period, is observed. There is a need for the involvement of family, friends, and healthcare professionals so that women feel supported and can overcome this period, being able to differentiate between common changes of the period and when there are warning signs.

Table 1: Analysis and Judgment Matrix of Mental Health Care for Postpartum Women in PHC - Southern Region, Brazil, 2019

Critério ou indicador*	Rationale	ES**	OS** Case 1	OS** Case 2	OS** Case 3
Investigation of family and social support during prenatal and postpartum care	Understanding and involving the members of a woman's support network in her care, from the beginning of pregnancy, provides opportunities for everyone involved to gain an understanding of the impact of motherhood on woman's emotional health and well-being. It also addresses the psychosocial factors affecting family relationships. This network should be investigated at each postpartum contact.[12]	1	0.4	0.2	0.7
Investigation of the history of mental health issues during prenatal and postpartum care	All pregnant women should be asked about a family history of bipolar disorder or postpartum psychosis, whether the woman has or had any mental illness, and the existence of previous treatments for mental health problems.[12]	1	0.8	0.4	0.6
Investigation of emotional state during postpartum care	The healthcare professional should ask brief, focused questions with simple ("yes" or "no") responses addressing women's moods to detect signs of Postpartum Depression (PPD): "During the last month, have you frequently felt bothered by feeling depressed or hopeless?" and "During the last month, have you been bothered by having little interest or pleasure in doing things?" If yes, inquire, "Is this something you would like help with?".[13]	1	0.2	0.2	0.5
Guidance on common emotional changes postpartum	Between 10 and 14 days after childbirth, healthcare professionals should inquire about the resolution of symptoms of transient postpartum depression (maternal blues). In the first two weeks, they should provide guidance on major emotional changes (fragility, hyperemotionality, mood swings, lack of self-confidence, feelings of incapacity), indicating that these are transient symptoms resulting from the physical, emotional, and social changes inherent to the period.[13]	1	0	0	0.5
Application of a scale for PPD diagnosis when identifying warning signs	Non-specialist PHC professionals through the application of validated instruments can identify symptoms of PPD. The Edinburgh Postnatal Depression Scale is the most commonly used.[12-13]	1	0	0	0
		5	**1.4**	**0.6**	**2.3**
	ID = (ΣOS/ΣES*100)	**100 %**	**28%**	**16%**	**46%**

*Source of evidence: Interviews (professionals and users); medical records.
*Parameter: Fully meets (1) Partially meets (0.9 to 0.1) Does not meet (0).
**ES: Expected score; OS: Observed score.

Lack of healthcare professionals' assistance to postpartum women after childbirth

The first category identified that women experienced emotional changes in the postpartum period and, in general, were unaware of the subject. Despite this, out of the 31 postpartum women interviewed, 21 were not even asked about mental health, nor were they explained what PPD would be. Of these, eight reported that they were asked about their feelings when they had a history of emotional changes, such as recent family death or a previous diagnosis of mental disorder.

No one ever said it was normal." (C1M4)

"No. Chest pain, no, but I cried. Oh, I think it was about three days after we got home. They didn't even guide me on that in the hospital." (C1M1)

"Sometimes I get sad. In general, people don't ask much about you; it's more about the baby." (C1M10)

From this analysis, it is evident that healthcare professionals according to the postpartum women's statements did not perceive emotional changes. Still, when questioned, they reported that such information is provided, showing contradictions between reports.

It depends on the postpartum woman's needs, then I'll see if she's okay, receives guidance, has few or no doubts, has no need for anything, I don't refer. Now, the one I feel has something more, I propose myself. (C2P5)

I usually provide guidance. I have a tendency to see what comes from her demand, even not to induce a behaviour. But I usually take care of the emotional part, from the beginning of gestation. And I reinforce the issue of guilt, not feeling guilty. Trying to explain the difference between this anguish, which is normal, a certain melancholy in the

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postpartum, which is normal, she may be more tearful, but trying to differentiate from postpartum depression. (C3P4)

The healthcare professionals use a non-verbalized approach in their interactions, meaning they do not directly ask questions related to feelings of sadness and abandonment. This led postpartum women to be unaware that they were being assessed, as there were no inquiries about these matters. Professionals reported conducting a preliminary analysis, where they visually assess the postpartum woman's state, determining if she appears sad, disheartened, or tearful. Only if these signs are noticed, they inquire about their feelings and provide guidance, limiting the opportunity for all women to speak, regardless of their situation.

It is emphasized that this analytical approach, as per the reported accounts, means many women with emotional changes do not receive a comprehensive examination from the professional, as crucial information ends up being overlooked.

To assist in this assessment, healthcare professionals were questioned about their prior knowledge and/or use of any type of tool to identify the PPD. Upon analysing the interviews, it becomes clear that scales were not used in any of the three cases in the study.

Unfortunately, I don't use a scale. I don't think I even knew we had one. I confess to you that I never even asked myself. Nowadays, everything is stratified, but for this one, I didn't even think about it. (C1P5)

No, we rely more on conversation. (C2P3)

I've heard of the scale, but I don't use any. (C2P4)

Despite the indispensable need for using such a tool to stratify risk and provide quality care, it was noted that the interviewed professionals lacked knowledge about it. They mentioned that consultations are based on observing the emotional state of the postpartum woman, as evident in their accounts. This reveals that postpartum women ended up mediating the consultations.

The lack of information, caused by a lack of assistance, leads to frustration due to not knowing what to do in moments when there are many doubts and no answers. Another important aspect identified in the interviews was that among the postpartum women who did not receive information about what to do regarding their feelings, some reported that one of the ways to obtain information was through internet searches or by consulting with family members.

Here, no one guided me. I think it was mentioned at one of the meetings here. When this happened to me, I didn't know, so I started researching postpartum depression symptoms on the internet, and I had all of them. Then I called and told my mom, and she said it was normal, that she also had it and such. My mom helped me. I didn't get to mention this during the consultation. (C2M10)

As we know, it is necessary to filter the vast amount of information found, as not everything on the internet is scientifically substantiated—valid arguments with proven efficacy. In other words, one can encounter the so-called "fake news," false information circulating in the media that can have negative influences on users.

This could be minimized if there were information dissemination within the health unit itself, including guidance on accessing reliable sources on the internet.

Discussion

With the birth of the baby, the woman and her family begin a new daily routine, which can be frustrating due to the challenges of the mother-child relationship, family nucleus reorganization, anxiety, and breastfeeding, which may require many readjustments to this new moment in her life.[14]

In this aspect, the present study identified that women go through feelings of abandonment and sadness during the postpartum period, and often, due to a lack of knowledge on the subject, they do not share their suffering and do not receive family and professional support.

A study indicates that experiencing sadness in the last trimester of pregnancy and a history of depression in the family are associated with a higher prevalence of PPD[15], reinforcing the recommendations of the present study regarding the investigation of the history of mental distress/illness during prenatal and postpartum periods.

The literature points out that emotional, instrumental, and informational support from the partner is fundamental, finding that the more support, the lower the prevalence of PPD[16] (Ramos, 2022). Similarly, support from the healthcare team to women during prenatal care reduces the prevalence of PPD by up to 23%.[15]

There is a need for planning and organization regarding these issues, as this allows doors to open for comprehensive care that meets the health needs of these women. Access to healthcare services contributes to reducing maternal mortality and ensuring comprehensive women's health care.[17]

In this process, it is essential to identify the weaknesses that may exist in prenatal care and point out possible strategies for the effectiveness of care provided until the postpartum period.[17]

One strategy that could be used for a broader assessment of the subject is the application of simple questions that identify possible emotional changes, namely: “During the last month, have you felt depressed or hopeless frequently? Did this bother you? During the last month, have you had little interest or pleasure in doing things? Did this bother you?”.[13]

Additionally, it is worth mentioning the Edinburgh Postnatal Depression Scale, one of the main instruments for identifying PPD in the context of PHC, as it is quick to apply, simple, and easy to understand. It can be self-

administered or administered by third parties (health professionals), associated with its value in identifying risk factors for PPD, as the psychosocial factor is relevant.[14] The application takes approximately five minutes, categorized with ten items divided into depression and anxiety factors, measuring the presence and intensity of symptoms in the last seven days. There are also differences related to the most indicated cutoff point for identifying PPD, which can be explained by methodological and inter-regional variations.[14]

Thus, it becomes indispensable to identify these signs in the patient's own speech through anamnesis, and in the face of a positive response, the Edinburgh Postnatal Depression Scale can be applied, used to identify PPD.[18]

It is crucial that healthcare professionals, especially nurses who are closer to women throughout the gestational and postpartum periods, have knowledge about PPD and can identify factors or conditions that may worsen their health. This enables them to assist women at the onset of symptoms and refer them to specialized care when necessary.

The literature points out that a certain lack of preparedness among healthcare professionals who do not have a well-defined definition of PPD or other mental disorders may emerge in the postpartum period. This difficulty complicates relating such disorder to factors that may cause greater harm to the postpartum woman.[19]

Regarding internet searches to address their doubts, considering that, although there are numerous websites containing health-related information, the users' ability to find scientifically robust health interventions is not fully known.[20]

Therefore, it is important for professionals to recognize this reality and assist women in making the best choices in seeking information, in addition to incorporating digital communication tools in care, such as teleconsultation, emails, apps, among others.[21]

Conclusion

The study's main contributions demonstrate that mental health care is fragile, and there is a need for improvement and strengthening of PHC professionals since they are the primary providers of postpartum care, especially nurses, who are qualified to provide quality and timely postpartum consultations. There is need for investment in the continuing education of professionals so that they promote health education practices related to the topic.

Study limitations

This study has the limitation of not allowing a comprehensive analysis covering all Brazilian municipalities and states as a whole. In other words, it does not permit the generalization of data beyond the investigated reality.

Authors' contributions

Almeida, O. M: Conception and design of the study, data collection, data analysis and interpretation, statistical analysis and writing of the manuscript.
Baratieri, T: Study conception and design, data collection, data analysis and interpretation, statistical analysis, obtaining funding and writing the manuscript.
Natal, S: Conception and design of the study, analysis and interpretation of the data, statistical analysis, and critical revision of the manuscript.
Krulikowski, I. B. O: Analyzing and interpreting the data, statistical analysis and writing the manuscript.
Cavalcante, M. D. M. A: Data analysis and interpretation, statistical analysis, and critical revision of the manuscript.
Malaquias, T.S.M: Data analysis and interpretation, statistical analysis, and critical revision of the manuscript.

Conflicts of interest and Funding

No conflicts of interest were declared by the authors.

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