PENSAR ENFERMAGEM
Revista Científica | Journal of Nursing

Strengths-Based Care: A Postpartum Plan for a Positive Fourth Trimester Experience

Berta Susana de Almeida Nunes da Pena[1]
orcid.org/0009-0000-9164-6058

Maria Anabela Ferreira dos Santos[2]
orcid.org/0000-0002-1675-5227

[1] Master's, Nurse at USF Querer Mais, Local Health Unit Arco Ribeirinho, Member of the Lisbon Nursing Research, Innovation and Development Center (CIDNUR), Lisbon, Portugal.

[2] Coordinating Professor at Nursing School of Lisbon, Lisbon. Member of the Lisbon Nursing Research, Innovation and Development Center (CIDNUR), Lisbon, Portugal

Abstract

Introduction
The fourth trimester, or postpartum period, places the woman (newborn and couple) at the center of family care. In this study, an instrument was developed to enable the postpartum woman or couple to plan and organize the postpartum period, facilitating adaptation during this time, guided by Laurie Gottlieb's theoretical framework on Strengths-Based Nursing Care.

Objective
The study begins with the research question: What difficulties does the postpartum woman experience? The objectives are to identify the bio-psycho-social needs of the triad in the first 12 weeks postpartum, the strategies of the postpartum woman or couple to overcome perceived difficulties, and the items to be included in the postpartum plan from a maternal perspective.

Methods
A descriptive exploratory study using a mixed-methods approach was conducted with a questionnaire administered to mothers aged 18 to 39. The study garnered 141 responses that met the eligibility criteria from April 14 to May 5, 2023. The data collection instrument was shared via mother groups on social networks (Facebook, Instagram, and WhatsApp). Content analysis was conducted according to Bardin, employing semantic categorization in the treatment of qualitative data and statistical analysis of quantitative data.

Results
The study uncovered the difficulties, the needs of the triad in the first 12 weeks, the strategies or strengths to overcome these difficulties, and the suggested items for the postpartum plan.

Conclusion
The study concludes that the postpartum plan is an innovative concept, as pregnant women or couples often focus on developing the birth plan, frequently overlooking or undervaluing the postpartum plan. However, most participants considered planning to be one of the strengths or strategies for a positive experience in the fourth trimester.

Keywords
Nurse Midwife; Women's Health; Holistic Nursing; Strengths-Based Care; Postpartum Period.

Corresponding Author:
Berta Susana de Almeida Nunes da Pena
Email: penal@campus.esel.pt

Recebido: 03.01.2024
Aceite: 16.04.2024

How to cite this article: Pena BSAN, Santos MAF. Strengths-Based Care: A Postpartum Plan for a Positive Fourth Trimester Experience. Pensar Enf [Internet]. 2024 Jun; 28(1): 61-73. Available from: https://doi.org/10.56732/pensarenf.v28i1.307

Introduction

The postpartum period encompasses a series of physical and psychological changes that occur after childbirth.[1] According to Chauhan and Tadi,[2] it begins following the expulsion of the placenta and continues until the complete recovery of various organic systems. This concept is based solely on anatomical and physiological principles. According to the definition of the postpartum period by the General Directorate of Health (DGS),[3] it is a period of maternal physical and psychological recovery that starts after birth and lasts up to 6 weeks postpartum.

The World Health Organization (WHO)[4] also considers the first 6 weeks as the defined duration for the postpartum period, dividing it into the immediate postpartum (first 24 hours), early postpartum (from the second to the seventh day), and late postpartum (until the end of the 6th week). Chauhan and Tadi[2] consider the late phase to last from 6 weeks to 6 months after childbirth.

According to Souza and Fernandes,[5] the postpartum period can last up to a year, adding a remote period from the 43rd day to one year postpartum.

The postpartum period is a time of transition, involving adaptations and physical, biological, familial, and emotional transformations reflected not only in individual care but also in the interactions that the woman establishes with her child, partner, and other family members. This is a moment of vulnerability where there are needs for social, physical, emotional, and informational support.[6] Despite being a phase of the pregnancy-puerperal cycle filled with many challenges and vulnerabilities, it is often the stage where the woman receives the least attention and support from health professionals.[5]

The needs felt throughout the postpartum period challenge healthcare professionals from prenatal care to prepare the woman for the situations she will experience in this new phase, as well as working with the family to strengthen relationships and prepare the support network for the arrival of the new member. In this sense, it is important to begin planning for the postpartum period during pregnancy.[7,8,6] According to Savage,[9] birth planning should go beyond labor and delivery and include the following weeks, with early discussions about infant feeding, postpartum emotional health, the challenges of parenthood, and postpartum recovery from birth, including the support network.[7, 9]

Continuous postpartum support centered on the woman is a recommendation from The American College of Obstetricians and Gynecologists (ACOG),[7] considering this period as the fourth trimester in which it recommends that there should be more than one consultation during at least the first 12 weeks. The fourth trimester concept refocuses attention on this period, considering the challenges and needs of the postpartum woman, newborn, and couple integrated into their family environment. ACOG also reinforces in the same recommendation the shared decision-making between the healthcare professional based on scientific evidence and the postpartum woman with her experiences and values.

The transition to motherhood develops in four distinct phases, according to Mercer,[8] where the first phase occurs during pregnancy and involves bonding with the fetus and preparing for childbirth and motherhood; the second, during the first two to six weeks postpartum, is crucial for postpartum recovery and acquiring knowledge to care for the baby; the third, between two weeks and four months, is about adjusting to daily life; and lastly, the fourth phase, around four months, consists of achieving maternal identity. The father also goes through a transition process that begins between the fourth and fifth month of pregnancy, a time when he starts to feel the first fetal movements and experiences feelings such as the desire to be present at childbirth and anxiety about the approaching moment when the experience of fatherhood develops with the relationship with the baby in the new routines after birth.[10]

The fourth trimester also encompasses all practices that simulate the intrauterine environment (swaddling, shushing, side/stomach position, swinging, and sucking), resembling an external gestation; it is based on the principle that the baby needs at least three months of adaptation to the extrauterine environment, according to Lima et al. (2017), cited by Sequeira et al.[11]

Hannon et al.[12] emphasize the importance of including health and well-being, not just the absence of morbidity, in a holistic view of care during this phase of motherhood. A positive experience of pregnancy, childbirth, and the transition to motherhood is a highly desirable outcome for all women. A positive postnatal experience is defined as one in which women, partners, parents, caregivers, and families consistently receive information and reassurances from motivated health professionals. The health, social, and developmental needs of women and babies are recognized within a health system that is resourceful, flexible, and respectful of their cultural context.[4]

Strengths-Based Care (SBC) by Laurie Gottlieb[13] takes a holistic approach that centers on the individuality of the person, considering strengths and potentials embedded in their environment. Beyond person-centered care, it is based on three additional pillars: the empowerment movement, collaborative partnership, and health promotion and prevention—which encourage the individual to take responsibility for their health, recovery, and healing, according to the author. This theoretical framework is more than just a model; it is a philosophy with roots fundamentally in Florence Nightingale's approach to nursing.[14]

For Gottlieb, strengths are "the qualities, skills, competencies, capabilities, and abilities that are distinct and separate, coexisting with weaknesses," which define "the individuality of the person and give expression to their humanity."[13(p.126)] According to the same author, strengths

can be biological, intra- and interpersonal, and social (resources and goods), which help individuals cope with challenges, achieve goals, and integrate these aspects into the totality of their being, committing to their self-development. In the author's holistic view, all aspects of a person—body, thoughts, emotions, consciousness, spiritual bonds, social relationships, and coping abilities—work together to make the individual feel complete and whole. Social resources, which are in the person's immediate environment, may include finances, family relationships, religion, community, and similar elements.[13] The person must be aware of available resources to mobilize and access them.

Strengths-Based Care (SBC) employs positive language such as strength, energy, challenges, opportunities, and possibilities, representing a language of hope. It involves a collaborative relationship in which the nurse and the team, along with the person and the family, make decisions, create the plan, and work together to find solutions. The feelings, thoughts, and experiences of the person are valued. It focuses on the individual's health and life.[13]

According to Gottlieb,[13] when individuals, families, and communities believe in themselves and focus on the positive aspects, they are respected; and when they have resources available to find solutions to their problems, they are more likely to build a sustainable future for themselves and their children.

This is evidenced by similarities between this theoretical model and the philosophy of care of the Nurse Specialist in Maternal and Obstetric Health (EESMO), where Barradas et al.[15] emphasize empowerment, woman-centered care, and the partnership between the woman and the EESMO nurse from a holistic perspective, giving the nurse the responsibility to provide care with flexibility and creativity to empower and support.

In this sense, it is essential to empower the woman, the couple, and the family for the fourth trimester so that strategies based on their strengths and potentials can be created to overcome and minimize the challenges they may face in a healthy environment.

This study was conducted as part of a Master's Thesis in Maternal and Obstetric Health Nursing and arose from the idea of developing a tool to plan and organize the postpartum period, focusing on low-risk pregnancies and thereby aiding adaptation during this time. A scoping review was previously conducted that mapped the evidence concerning the theme.

The study begins with the research question: What difficulties do postpartum women experience? The objectives are to identify the bio-psycho-social needs of the triad in the first 12 weeks postpartum, the strategies of the postpartum woman/couple to overcome perceived difficulties, and the items to be included in the postpartum plan.

Methods

A descriptive exploratory study using a mixed-methods approach was conducted. The inclusion criteria included mothers aged between 18 and 39 at the time of childbirth, with healthy children born within the last three years. Exclusion criteria applied to situations where either the mother or the baby experienced health complications that required hospitalization beyond the typical postpartum stay, as these cases have specific needs. Mothers at the extremes of the reproductive age range were also excluded as they are considered high-risk pregnancies according to the modified Goodwin scale.[3]

The data collection tool was a questionnaire developed in Google Forms, featuring both open and closed questions. It consisted of 53 questions divided into four sections: sociodemographic data, information about pregnancy and childbirth as referred to in the questionnaire, details about the postpartum period, and the postpartum plan.

In October 2022, a questionnaire evaluation was conducted with eight mothers who met the inclusion criteria to assess clarity, acceptability, comprehension, and item reduction.[16] This evaluation also involved mothers who are nurse specialists in maternal health, providing not only the perspective of a mother but also that of a health specialist. As a result, semantic validation was performed, which clarified the language[16] and enhanced the understanding of the content, with all suggested modifications being incorporated.

A non-probabilistic convenience sample was chosen because it allows for a quicker and less costly study, as noted by Vilelas.[16] The "snowball" sampling technique, or network sampling, was utilized. The data collection tool was initially shared through mother groups on social networks (Facebook, Instagram, and WhatsApp) and through personal acquaintances with mothers who met the inclusion criteria. There was a request to further share it with others who met the criteria from April 14 to May 5, 2023.

In total, 146 responses were obtained, but five questionnaires (Q9, Q14, Q18, Q21, and Q28) were excluded because they pertained to situations of hospitalization in neonatology, resulting in 141 participants being included.

Statistical analysis of the quantitative data was performed. Content analysis was carried out according to Bardin.[17] This involves three phases: pre-analysis; material exploration and treatment of results; and inference and interpretation. In the pre-analysis phase, a "floating reading" was conducted to get an overall idea of the content. Each questionnaire was assigned a code in the order they were completed (first questionnaire - Q1).

The material exploration phase, comprising the actual analysis,[17] was conducted using WebQDA – Qualitative Data Analysis software and the Microsoft Office Excel

DOI: 10.56732/pensarenf.v28i1.307

software program. Finally, the treatment of the results obtained and their interpretation took place, where the raw results were analyzed to produce meaning.[17] This phase involved the synthesis and selection of results, inferences, and interpretation.

Categorization facilitates organizing content by grouping information into categories based on previously established criteria, which can be semantic, syntactic, lexical, and expressive.[17] In this context, a table was prepared with categories, subcategories, and the respective registration units that determine them and are relevant to the study objectives. Semantic categorization, which groups by themes,[17] was employed according to the objectives, the scoping review, and the theoretical reference to Strengths-Based Care (SBC) (Table 4).

The data concerning the items for constructing the postpartum plan were collected through open and closed questions, thus they were subjected to both qualitative and quantitative analysis.

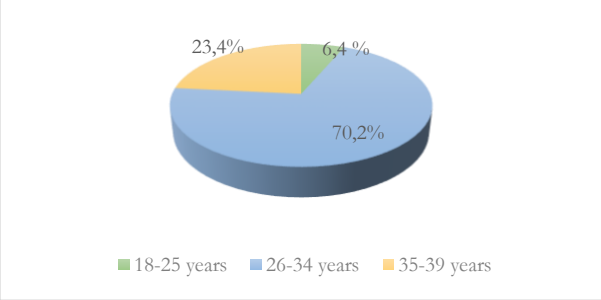
In this research, all ethical procedures were strictly adhered to since the questionnaire was completed anonymously via Google Forms, ensuring that neither the researchers had access to the identities of the participants. Informed and explicit consents were obtained in the questionnaire, specifically in the introduction in which the study objectives were presented, ensuring confidentiality, self-determination, and anonymity. The online nature of the questionnaire was beneficial for participants as it allowed them to choose when and where to respond, and their participation was optional. No risks were identified for the research subjects.

Results

The results of the study emerged from both closed and open questions.

The age of the participants at the time of childbirth was predominantly between 26 and 34 years old (n=99), followed by 35 to 39 years old (n=33) and 18 to 25 years old (n=9).

Graph 1 - Distribution of the sample by age at the time of childbirth (n=141)



Most responses indicated that the postpartum mothers have a master's degree (42.5%) and a bachelor's degree (34%), with the lowest level of education being the second cycle of basic (elementary) education and the highest being a doctorate.

Regarding their profession, according to the Portuguese Classification of Professions,[18] 42.5% are specialists in intellectual and scientific professions, followed by 15.5% as technicians and intermediate-level professionals, and 14.9% in administrative, services, and similar roles. Of the participants, 19.8% work in the maternal and child health area.

The majority are Portuguese (97.9%), with two Brazilians and one South African, married (52.5%), in a common-law marriage (39.7%), single (7.1%), and one widow. As for the type of family, the majority are nuclear (82%) (Table 1).

Table 1 – Identification data

	Absolute Frequency	Relative Frequency (%)
2. Age at the time of the childbirth referred to in the questionnaire		
18 - 25 years	9	6.4 %
26 -34 years	99	70.2 %
35-39 years	33	23.4 %
3. Education		
No schooling	0	0 %
Basic education 1st Cycle - primary (currently 4th grade)	0	0 %
Basic education 2nd Cycle - elementary (currently 6th grade)	2	1.4 %
Basic education 3rd Cycle - middle (currently 9th grade)	2	1.4 %
High school (currently 12th grade)	17	12.1 %
Post-high school (non-degree technology specialization courses)	3	2.1 %
Higher technical professional course	4	2.8 %
Associate degree (includes former intermediate courses)	0	0
Bachelor's degree	48	34 %
Master's degree	60	42.5 %
Doctorate	4	2.8 %
Other: Bachelor's degree and Postgraduate	1	0.7 %
4. Profession		
Unemployed	11	7.8 %
Unskilled worker	13	9.2 %
Farmers, Factory Workers, Artisans, and other Skilled Workers	4	2.8 %
Administrative, Service, and Similar Staff	21	14.9 %
Technicians and Associate Professionals	22	15.5 %
Specialists in Intellectual and Scientific Professions	60	42.5 %
Unpaid domestic work	0	0 %
Senior officials of Public Administration, Directors, and Senior Managers of Companies	9	6.4 %
Military and militarized forces	1	0.7 %
5. Do you work in the maternal and child health area?		
Yes	28	19.9 %

No	113	80.1 %
6. Nationality		
Portuguese	138	97.9 %
Other: Brazilian	2	1.4 %
Other: South African	1	0.7 %
7. Marital Status		
Single	10	7.1 %
In a common-law marriage	56	39.7 %
Married	74	52.5 %
Divorced	0	0
Widowed	1	0.7 %
8. Family Type		
Nuclear (couple with common children)	116	82 %
Extended (couple, children, and family relatives)	9	6.4 %
Blended (couple with children from previous relationships)	11	7.8 %
Single parent (mother with children)	4	2.8 %
Single-person (consists of one person living alone)	0	0 %
Other: Mother, daughter, and grandmother	1	0.7 %

Most of the participants are primiparous; however, in 39 responses, other siblings of the baby were living in the same house during the first weeks postpartum.

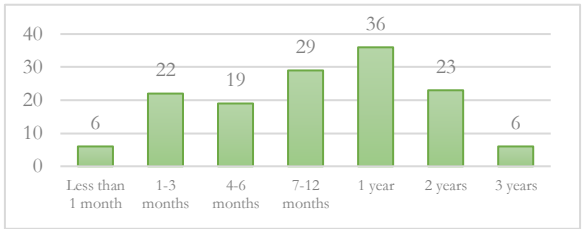
The majority of the participants experienced a dystocic birth (54.6%), mostly cesarean (n=48). Sixty-four participants had an eutocic birth (Table 2).

Table 2 – Data on pregnancy and childbirth referred to in the questionnaire

	Absolute Frequency	Relative Frequency (%)
9.Number of siblings of the baby living in the same house during the first 12 weeks postpartum		
0	102	72.3 %
1	29	20.6 %
2	9	6.4 %
3	1	0.7 %
10. Current age of the baby/child		
Less than 1 month	6	4.3 %
Between 1 and 3 months	22	15.6 %
Between 4 and 6 months	19	13.5 %
Between 7 months and 1 year	29	20.6 %
1 year	36	25.5 %
2 years	23	16.3 %
3 years	6	4.3 %
11. Did you take a course on childbirth and parenting preparation?		
Yes	89	63.1 %
No	52	36.9 %
I don't know what it is	0	0 %
12. Type of Birth		
Eutocic (natural birth)	64	45.4 %
Vacuum (vaginal delivery using a vacuum)	23	16.3 %
Forceps (vaginal delivery using forceps)	6	4.3 %
Cesarean (birth through surgery)	48	34 %
13. Did you make a birth plan?		
Yes	73	51.8 %
No	68	48.2 %
I don't know what it is	0	0 %
14. Did you make a postpartum plan?		
Yes	13	9.2 %
No	118	83.7 %
I don't know what it is	10	7.1 %

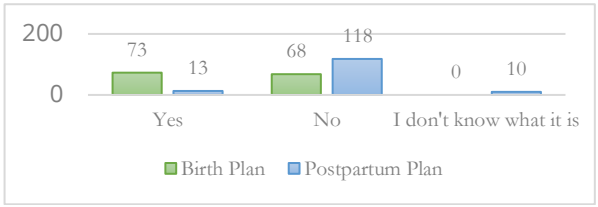
As for the ages of the babies/children, they range widely from newborn to 3 years according to Graph 2.

Graph 2 - Distribution of the sample by current age of the baby/child (n=141)



Most participants attended the birth and parenting preparation program (63.1%); however, only 10.6% of the participants completed the postpartum recovery course. Additionally, while the birth plan was a concern for most respondents (51.8%), only 9.2% of the participants created a postpartum plan, and 71% reported being unaware of it (Graph 3).

Graph 3 - Distribution of the sample concerning the realization of the birth plan and postpartum plan (n=141)



The data regarding the postpartum period of the participa nts are shown in Table 3.

Table 3 – Data on postpartum

	Absolute Frequency	Relative Frequency (%)
17. During which postpartum periods did you experience difficulties?		
First 2 hours (delivery room)	5	3.5 %
Hospitalization (postpartum ward)	21	14.9 %
Returning home after discharge from the postpartum ward	26	18.4 %
Partner returning to work	19	13.5 %
Returning to work (if returned before 12 weeks postpartum)	3	2.1 %
Other: Isolation	1	0.7 %
Other: First weeks	1	0.7 %
Other: None	1	0.7 %

DOI: 10.56732/pensarenf.v28i1.307

Other: Period of adaptation to breastfeeding	2	1.4 %
Other: First 2 to 3 weeks postpartum	2	1.4 %
Other: Time when left without support	1	0.7 %
No response to the question	59	41.8 %
20. Was the baby/child breastfed?		
Yes	138	97.9 %
No	3	2.1 %
21. Was the decision to breastfeed or not made during pregnancy?		
Yes	133	94.3 %
No	8	5.7 %
23. Until what age was the baby exclusively breastfed (baby ingested only breast milk)?		
Less than 1 month	27	19.1 %
Up to 2 months	8	5.7 %
Up to 3 months	6	4.3 %
Up to 4 months	10	7 %
Up to 5 months	12	8.5 %
Up to 6 months	44	31.2 %
The baby is not yet 6 months old and I am exclusively breastfeeding	34	24.1 %
24. When did you stop breastfeeding (exclusive breast milk or not)?		
Less than 1 month	10	7 %
Between 1 to 2 months	10	7 %
Between 3 to 4 months	11	7.8 %
Between 5 to 6 months	7	5 %
Between 7 months and 12 months	9	6.4 %
Between 12 months and 18 months	7	5 %
Between 19 months and 24 months	2	1.4 %
2 years	4	2.8 %
3 years	0	0 %
Other: Still breastfeeding	59	41.9 %
Other: Not applicable	3	2.1 %
25. Was the duration of breastfeeding as you had planned?		
Yes	64	45.4 %
No, I breastfed longer than I had planned	14	10 %
No, I breastfed for less time than I had planned	40	28. 4 %
29. Did you take a postpartum recovery course?		
Yes	15	10.6 %
No	126	89.4 %
30. Was self-care, such as eating, bathing, exercising, sleeping, etc., a concern during this period?		
Yes	99	70.2 %
No	42	29.8 %
33. Did you feel that there was a change in your relationship with your partner?		
Yes	104	73.8 %
No	37	26.2 %
36. If you used a contraceptive method postpartum, was it chosen during pregnancy?		
Yes	71	50.4 %
No	66	46.8 %
45. Were the aspects facilitating a positive postpartum experience planned/prepared in advance?		
Yes	70	49.6 %
No	71	50.4 %

Postpartum Difficulties:

Challenges in baby care were noted, specifically in *"managing the nights, colic (up to 4 months)," "traveling (baby hates car rides)," Q11, "cutting nails and umbilical cord hygiene," Q17,* and *"fear of making mistakes," Q54*. Breastfeeding is identified as one of the challenges; three participants did not breastfeed—one by choice (Q128), one for maternal reasons (Q121), and one due to difficulties in latching (Q126). Out of the participants, 41.9% were still breastfeeding at the time of filling out the questionnaire, 31.2% exclusively breastfed up to 6 months, and 45.4% continued breastfeeding as planned.

Some participants expressed difficulties in breastfeeding, such as: *"The baby had a short frenulum and we didn't know," Q16, "Difficulty in latching. This led to significant weight loss, sore nipples, unbearable pain, beginning of mastitis, severe fatigue, and difficulty managing emotions associated with this challenge," Q39*.

Self-care is a concern for the majority of participants (70.2%), with physical and psychological recovery being another challenge reported by the study participants, notably: *"vaginal pains," Q1, "deprivation of sleep, intense insomnia, anxiety, difficulty being confined with the baby, desire to return to a routine, identity crisis, baby blues," Q32, "great difficulty in showering, going to the bathroom, walking, lifting, holding the baby, sitting down. It was very difficult," Q40, "emotional exhaustion and doubt about what I was doing with my life," Q68*.

Marital relationship is impacted by difficulties in parental roles, marital relationship, and sexuality. In the transition to parenthood, it is mentioned how the relationship can influence this transition and vice versa: *"Different views on motherhood," Q25*. Of the participants, 73.8% reported changes in their relationship with their partner. Some difficulties in marital and sexual relationships expressed are: *"Difficulty in communication and having time as a couple," Q24, "Mainly about the care of the baby and help with household chores. The partner's work schedules made it difficult for him to be at home, which led to distancing and a feeling of loneliness where everything depended on me," Q39, "There is no marital life, only parenthood," Q61, "Lack of sleep makes me more irritable, lack of time and privacy for sexual activity," Q80*.

Regarding family planning, the majority chose the contraceptive method during pregnancy (n=71), however, one participant states that *"At the health center, they only asked me which contraceptive I wanted," Q82*.

The difficulties expressed by participants regarding the support from health professionals and family or friends within the support network include: *"Overload when my partner went to work," Q4, "Lack of support in breastfeeding," Q6, "Social pressure to work," Q16*. Health professionals were described as *"uninformed, inconvenient, and persistent in their opinion," Q17, "providing contradictory information," Q24, "During COVID, I expected my family to be more present, but that was an illusion," Q56, "People help with the baby on the easy parts but not with the more difficult tasks (household chores, cooking, etc.)," Q80, "I did not even have consultations at the national health service," Q86*.

Managing daily life presents another challenge, specifically the management: *"Lack of time/opportunity to do household chores," Q42, "Dealing with the older one," Q57*. Managing visits was challenging: *"Difficulty in setting limits during visits, the timing of visits, contact with the baby, and dealing with unsolicited,*

judgmental opinions," Q82. Returning to work was also problematic due to *"the absence of paternity leave because he is a service provider and maternity leave being ridiculously short," Q37, "Lack of sleep drains energy needed for managing work-family-home time," Q49, "Balancing work schedules with daycare," Q126,* and *"Ability to replan professional future," Q135.*

Needs of the Triad from the Participants' Perspective

The identified needs of the triad include informational needs such as *"care that the mother should have with herself in terms of nutrition, supplementation, and body care in the postpartum period," Q33,* and *"information about what are warning signs in the baby, what can happen, what is normal or not," Q40.* Physical and biological needs were expressed as *"finding time for myself to do sports, to take care of myself," Q59,* and *"need for constant hygiene," Q70.* Psychological and emotional needs were noted for both the baby, as in *"her need to always be in my lap or with me close to her," Q66,* and for the mother/couple: *"need for emotional support," Q16.*

Social needs included *"help with chores and baby care," Q2, "psychological support," Q8, "holding the baby for a few moments, making food," Q20.* One participant noted, *"some [support] would already be good. For 99% of the design of the follow-up by health professionals in the system, the fourth trimester does not exist," Q34.* Additional needs mentioned were *"home visits in the postpartum period for conducting the heel prick test to assess maternal and newborn well-being," Q52,* and *"Household chores, laundry treatment, meals, and activities of the siblings," Q61.*

The Strengths that Contributed to a Positive Fourth Trimester Experience

The strengths that emerged from this study, contributing to a positive fourth trimester experience, include experiences, cognitive strengths, biological and intrapersonal strengths, psychological strengths, relational and affective strengths, social and interpersonal strengths, creating a plan, collaborative partnerships, and promoting a protective environment.

Experiences as described include: *"Having had a natural, humanized, and respected childbirth. Being the second experience," Q15; "The childbirth experience was positive, very supported by the nursing team, with no unnecessary instruments or cuts. It made my recovery much quicker and lighter," Q44.* Cognitive strengths were highlighted as *"Many videos on the internet plus support from the nurse," Q26; "...seeking information in books written by nurses and/or doctors," Q104.*

Biological and intrapersonal strengths expressed included comments like *"I think I had an excellent recovery because I did not have significant sequelae from childbirth," Q2*, and *"The baby being calm," Q5.* Psychological strengths were highlighted through reflections such as *"simply looking in the mirror," Q5; "Mindfulness and recognizing that I cannot control everything," Q41; "Trusting myself, my partner, and my baby," Q53; and "Breathing deeply and always acting calmly and asking for help whenever I need it," Q76.*

Relational and affective strengths like *"Dialogue," Q2; "Babywearing," Q12; "A lot of cuddling," Q31;* and *"We did everything together with a lot of respect for the process I was going through and a lot of understanding about each other's roles. He took care of me so that the postpartum process was more serene," Q53,* were vital. Social and interpersonal strengths were evident as participants mentioned, *"I put him in daycare before returning to work so I could sleep while he was there," Q12; "Family support and medical help," Q8; "Sharing groups on social networks," Q10; and "Postpartum home visit," Q25.*

Further strengths included *"Support consultations for breastfeeding, speech therapy, and physiotherapy," Q44; "Good medical team, good nurses," Q60;* and *"Shared parental leave with the father," Q62.* Plans were created such as *"Once a week we go out just the two of us," Q4; "Try to talk a little at night 2x/week," Q11;* and *"Having specific appointments and routines," Q77.*

Collaborative partnerships were described as *"Support from the baby's father," "I could only manage when the father came home," Q3; "Dividing tasks at home, for example, while I was breastfeeding, father made the meals," Q25;* and *"Delegating tasks to the father," Q82.* Additionally, promoting a protective environment was crucial, including practices like *"Rooming-in," Q62; "The father being with me and us being alone in the room," Q66;* and *"Leaving the hospital as soon as possible. A 36-hour hospital stay," Q89.*

Table 4 - Categories and subcategories

Categories	Subcategories
Postpartum Difficulties	Baby Care Breastfeeding Physical and Psychological Recovery Transition to Parenthood Marital Relationship Family Planning Support Network Daily Life Management
Needs of the Triad from the Participants' Perspective	Informational Physical and Biological Psychological and Emotional Social
The Strengths that Contributed to a Positive Fourth Trimester Experience	Experiences Cognitive Strengths Biological and Intrapersonal Strengths Psychological Strengths

DOI: 10.56732/pensarenf.v28i1.307

Relational and Affective Strengths
Social and Interpersonal Strengths
Creation of a Plan
Collaborative Partnership
Promotion of a Protective Environment

Items for Elaborating the Postpartum Plan

The items for elaborating the postpartum plan were obtained through five closed questions from Section IV of the questionnaire (Table 5), with an option for a free text response, and from open questions, specifically questions number 15, 16, and 53.

Table 5 – Postpartum plan

	Absolute Frequency	Relative Frequency (%)
46. What options did you define or consider important to reflect on/define during pregnancy?		
The option to breastfeed or not	108	76.6 %
Type of contraception intended for postpartum	49	34.8 %
Contacts of family and friends who can support postpartum	105	74.5 %
Mother groups (online, in-person)	54	38.3 %
Contacts of health professionals (Hospital, Health Centers, others)	102	72.3 %
First contact with health professionals (who, how)	71	50.4 %
Who to contact for breastfeeding support	121	85.9 %
Who to contact if experiencing feelings of sadness	101	71.6 %
Postpartum recovery course	68	47.6 %
Other: Information	2	48.2 %
Other: Doula	1	0.7 %
Other: Logistics preparation of meals and household tasks	1	0.7 %
Other: Follow-up of mothers with pre-existing conditions that may complicate postpartum	1	0.7 %
Other: Pelvic physiotherapy	1	0.7 %
47. In the first 2 hours (delivery room), is it important for the mother/father to define in their plan:		
Presence of the father or another significant person	133	94.3 %
Skin-to-skin contact with the baby from birth (by mother, father, or another)	137	97.2 %
Breastfeeding in the first hour of life	128	90.8 %
Other: Delay non-urgent procedures	3	2.1 %
Other: Consent for the administration of medication	1	0.7 %
Other: Not dressing the baby to make skin-to-skin contact	1	0.7 %
Other: Privacy	1	0.7 %
Other: Information	1	0.7 %
Other: Immediate support in breastfeeding	1	0.7 %
48. During hospitalization (postpartum ward), is it important for the mother/father to define in their plan:		
Presence of the father or another significant person	139	98.6 %
Support in breastfeeding (how, who, when)	129	91.5 %
Protective options for breastfeeding (not introducing pacifiers, how formula milk or breast milk is offered if needed)	101	71. 6 %
First bath of the baby (who, when)	106	75.2 %
Presence during all procedures on the baby	114	80.9 %
Prior information to parents about all interventions on the baby (medication, treatments)	129	91.5 %
Visits (who, when)	104	73.8 %
Other: Privacy	1	0.7 %
Other: options in deviations from normality	3	2.1 %
Other: frequent skin-to-skin contact	1	0.7 %
49. Upon returning home, is it important for the mother/father to define in their plan:		
Organized baby clothes for the first days	87	61.7 %
Where the baby will sleep	98	69.5 %
Baby care (who, how)	110	78 %
Other children (care, interaction with the baby)	82	58.2 %
The first meals	81	57.4 %
Household tasks (who, how, when)	117	83 %
Visits (who, how, where, when)	122	86.5 %
Financial management (who and how bills are paid)	55	39 %
Care of pets (who, what)	64	45.4 %
Time for the couple (how, when, support network)	93	66 %
Time for self-care (what, who supports, when)	118	83.7%
Other: Car safety	1	0.7 %
Other: Family outings	1	0.7 %
50. Upon returning to work, is it important for the mother/father to define in their plan:		
Who will take care of the baby	132	93.6 %
Baby's feeding/breastfeeding (how, who, where)	126	89.4 %
Work conditions (schedules, what, from when)	129	91.5 %
Reorganization of household tasks (who, what, when)	114	80.9 %
51. In your opinion, should the postpartum plan be developed only by the mother or the pregnant woman?		
Yes	3	2.1 %
No	138	97.9 %
52. If not, indicate with whom the postpartum plan should be developed?		
With partner	138	97.9 %
With a family member	14	9.9 %
With a friend	5	3.5 %
With a maternal and obstetric health nurse	55	39 %
Other: Doctor overseeing the pregnancy	1	0.7 %
Other: Doula	3	2.1 %
Other: Information discussed with the EESMO nurse beforehand	1	0.7 %
Other: In conjunction with the support network	1	0.7 %

From the study, eleven items emerged for elaborating the postpartum plan: information, baby care, baby feeding plan/breastfeeding plan, recovery plan, family planning, marital relationship, support network, management of daily life, management of expectations, management of deviations from normality/complications, and planning and implementation (Table 6).

Table 6 – Items for elaborating the postpartum plan

Postpartum Plan Items	Quantitative Data	Qualitative Data
Information	x	x
Baby Care	x	x
Baby Feeding Plan/Breastfeeding Plan	x	x
Recovery Plan	x	x
Family Planning	x	x
Marital Relationship	x	x
Support Network	x	x
Daily Life Management	x	x
Expectations Management		x
Management of Deviations from Normality/Complications		x
Planning and Implementation		x

Information is necessary to create the postpartum plan as expressed by the participants: *"To have validated information on various areas of child health to manage daily life, especially important is the information on breastfeeding!" Q83,* and *"Demystify that the woman does not have to bear everything alone and that she does not have to be a superwoman at all" Q95.*

Regarding baby care, needs include: *"Stock of reusable diapers. Management of baby's wake and sleep times" Q16, "Postponing non-urgent procedures" Q20, "Baby care (e.g., not being separated, not bathing)" Q37, "...administration or not of medication and vaccines" Q66,* and *"Pregnant woman's and baby's bag, baby's bed and clothes (...) Car safety" Q74.*

For the feeding plan, needs are described as: *"Management of tandem breastfeeding" Q15, "Breastfeeding consultation" Q25, "...I separated breastfeeding-friendly clothes" Q38, "Breastfeeding accessories..." Q80,* and *"Immediate support in breastfeeding" Q128.*

Participants highlighted the importance of defining specific elements of the recovery plan: *"Frozen food, frozen perineal pads" Q20, "nutritional and exercise plan for the mother" Q45, "Comfortable, practical, and beautiful clothes for me (...) Importance of postpartum gymnastics not only for physical rehabilitation but also for emotional and social reintegration" Q79, "Recognizing warning signs of postpartum depression (...) Time for myself. When to start exercising" Q83.*

Only 34.7% of the participants considered it important to define the type of contraception intended for the postpartum period during pregnancy. However, one participant noted, *"Think carefully about postpartum contraceptive methods. The general choice is the pill and it may not be suitable, but we might not be in the right state of mind at that time to say no." Q64.*

Regarding marital relations, the participants emphasized: *"Very important in supporting the partner" Q19, "Family outings" Q81,* and *"Organizing timings with the father" Q86.*

A participant in the following way expressed the importance of planning the support network:

> *"Everything. (...)* ***Home****: - for four months, family brought food to freeze on weekends - an online shopping list to just click 'come' - twice a week friends brought soup - housekeeping help biweekly - teaching boyfriend how to do laundry...* ***Visits****: - extended family was informed throughout the pregnancy that we did not want visits unless we invited them first - this was respected. - immediate family (our parents) had to give us 24 hours alone with the baby at home (...)* ***Education of the support network****: - throughout the pregnancy, well before it, our options for the baby and how we wanted to guide her were exposed and discussed - ESSENTIAL (...).* ***Specialized support****: - support by (…).* ***Network of mothers with babies*** *of the same age - MY GOD ABSOLUTELY ESSENTIAL" Q19*

Regarding the management of daily life, the majority of participants considered it important *to "leave as many things done as possible" Q36, "restrict visits to just the grandparents, I made food before childbirth and froze it…" Q44.*

The participants considered it important to add the management of expectations: *"...adjusted expectations made the most difference." Q19, "Have a plan, but be open to the fact that things may not all go as we want" Q42,* and *"to be discussed with the person, not the importance of making decisions that may later prove to be unrealistic, but to reflect on each topic" Q37;* the management of deviations from normality as:: *"What to do in extraordinary situations like intensive care/neonatology." Q62, "Make a plan for if something goes beyond what we expect, what to do if something goes wrong" Q64, "What happens to the baby if something happens to the mother" Q75;* and the planning and implementation: *"...daily/hourly scheduling." Q45, "The postpartum plan should be part of the birth preparation course" Q71,* and *"It can be done online or at a distance, since it might not be appealing or possible to leave the house" Q93.*

The quantitative data are detailed in Table 1.

Most (98%) considered that the postpartum plan should be made with the partner (n=138), followed by 39% with a nurse specialist in maternal and obstetric health, adding that *"During pregnancy to have a consultation where the postpartum is discussed and not just about childbirth (childbirth passes quickly, the postpartum does not)" Q22.*

Discussion

This study revealed the difficulties in the postpartum period, the needs of the triad from a maternal perspective, the strengths that contributed to a positive experience in the fourth trimester, and the items for elaborating the postpartum plan. Concerning challenges in baby care, the results corroborate the study by Alves et al.[20], which states

DOI: 10.56732/pensarenf.v28i1.307

that postpartum women are afraid of bathing, caring for the umbilical cord, and soothing the child properly. Many of the difficulties in breastfeeding stem from a lack of support, insufficient information, pain, and negative emotions.[21,22] Research findings from Zivoder et al.[23] show that difficulties and psychological disorders in the postpartum period are common, affecting almost 50% of women (44.46%), with Baby Blues being the most prevalent, followed by postpartum depression and anxiety disorders. The study notes that age and type of birth do not influence the emergence of changes, whereas social factors such as family support have a significant impact. The difficulties in marital relationships expressed by the participants align with the study by Asadi et al.[24], which observes that relationships with partners evolve into a new form of cooperation for child care during this period. The challenges of managing daily life are supported by the studies of Ayers et al.,[25] Brown and Shenker,[26] Caetano et al.,[27] Hadjigeorgiou et al.,[28] Joy et al.,[29] and Sakalidis et al.[30] This study corroborates the results of the scoping review regarding maternal difficulties and concerns in the fourth trimester, except for the added difficulties related to multiculturalism, since the sample is predominantly Portuguese. The needs of the triad identified from the participants' perspective are supported by the study of Ribeiro et al.,[6] which concludes that there is a need for social, physical, emotional, and informational support in the postpartum period. McLeish et al.[31] also emphasize the necessity of emotional, informational, and practical support during this time. These authors argue that gentle, respectful, and empathetic interactions contribute to feelings of security and appreciation.

The strengths that contributed to a positive experience in the fourth trimester identified in this study include experiences, cognitive strengths, biological and intrapersonal strengths, psychological strengths, relational and affectionate strengths, social and interpersonal strengths, the creation of a plan, collaborative partnership, and the promotion of a protective environment. Information about breastfeeding typically comes from contact with health professionals during monitoring visits, courses, available literature, previous personal experiences, or those of relatives and friends, with mothers often being one of the largest sources of knowledge and direct support, as mentioned by Oliveira et al.[32] Greater partner support in the postpartum period is associated with higher self-efficacy in breastfeeding, less depression, and less body dissatisfaction.[19,33]

Acquiring new skills and abilities promotes the development of strengths, an opportunity created by transitions according to Gottlieb.[13] Additionally, the author[13] notes that the processes of body repair include strengthening the immune system, improving cardiac and renal function, and enhancing mind functionality, thereby addressing emotional, mental, and spiritual states. Restoring the whole involves acts of self-healing, such as balancing and resting activities, promoting sleep, exercise, eating well, promoting relaxation, and reducing stress.[13]

Besides being a moment of happiness, the fourth trimester can present considerable challenges for the woman, the couple, and the family, and it may also pose challenges at work, in the community, and in health policy. The results align with Hannon et al.,[12] who assert that health education focuses on supporting informed decision-making processes as a positive resource that alleviates concerns and difficulties. This includes care centered on the family—not just the baby—support in the postpartum period, and flexibility in returning to work, with accessible and nearby daycares.

It is important to highlight the items suggested for elaborating the postpartum plan, which include information, baby care, baby feeding/breastfeeding plan, recovery plan, family planning, marital relationship, support network, management of daily life, management of expectations, management of deviations from normality/complications, and planning and implementation. As Ribeiro et al.[6] emphasize, preparing the support network is crucial, especially for the immediate postpartum period, as it involves experiencing rapid changes in the body and routine that make the woman feel the need for support to cope with pain, breastfeeding difficulties, and newborn care, along with fatigue and the fear of the responsibilities that come with motherhood. The same author corroborates and highlights the importance of a positive childbirth experience, as well as changes in routines in the remote postpartum period.

It should be noted that Strengths-Based Care (SBC) provides a sense of centrality and empowerment in women, leading to more effective performance in their self-care, breastfeeding, and health promotion for returning to their routine, according to Silva et al.[34]

Conclusion

The fourth trimester is a concept that places the woman (newborn and couple) at the center of care within the family. This period requires time for the woman to adapt and to be supported by a network that offers practical support tailored to her needs and preferences. The challenges mentioned include baby care, breastfeeding, physical and psychological recovery, the transition to parenthood, marital relationships, family planning, the support network, and managing daily life. From the maternal perspective, the bio-psycho-social needs of the triad in the first 12 weeks postpartum were identified, along with the strategies of the postpartum woman/couple to overcome perceived difficulties, which facilitated the construction of items to be included in the postpartum plan.

The postpartum plan is an innovative concept, as pregnant women and couples often focus on developing the birth plan, frequently overlooking or undervaluing the

postpartum plan. However, most participants considered planning one of the strengths or strategies for a positive experience in the fourth trimester. Further research studies are suggested on the development of the postpartum plan in specific situations such as prematurity, disability, and involving the couple.

Study Limitations

The sample is predominantly Portuguese, which makes the group homogeneous on one hand, but on the other hand limits the understanding of perspectives on the postpartum plan and fourth trimester from various ethnic and cultural origins.
The online nature of the study limits the accessibility of participation homogeneously.
We could not extend the study to the paternal perspective by applying the questionnaire to the father/partner of the postpartum woman to know their perspective and suggestions, which would have been an added value.

Authors' Contributions
BP: Conception and design of the study, data collection, analysis and interpretation of data and writing of the manuscript.
MS: Guidance in the conception and design of the study, analysis and interpretation of the data and critical revision of the manuscript.

Conflicts of Interest and Funding
No conflicts of interest were declared by the authors.

Acknowledgments
The authors would like to thank all the participants in this study and the Nursing Research, Innovation and Development Centre of Lisbon (CIDNUR), which provided access to WebQDA - Qualitative Data Analysis software.

Support / Funding Sources
The study was not funded.

References

1. Ferreira AF. Fisiologia do puerpério. In: Néné M, Sequeira C, editors. Enfermagem de saúde materna e obstétrica. Lisboa: Lidel; 2016. p. 438–42.
2. Chauhan G, Tadi P. Physiology, Postpartum Changes. [Updated 2022 Nov 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555904/
3. Direção-Geral da Saúde. Programa nacional para a vigilância da gravidez de baixo risco. Lisboa: DGS; 2015. 112 p.
4. World Health Organization, Human Reproduction Programme. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneve: World Health Organization; 2022. 224 p.
5. Souza ABQ, Fernandes BM. Guidelines for nursing care: an effective tool for the promotion of health in puerperium. Rev Rene [Internet]. 2014 Aug. 20 [cited 01/09/2021];15(4). Available from: http://periodicos.ufc.br/rene/article/view/4887
6. Riberio JP, Lima FBC, Machado T, Soares S, Oliveira BB, Voss Klemtz F, et al. Needs felt by women in the puerperal period. J Nurs UFPE online [Internet]. 2019 [cited 01/11/2022]; 13(1):61–70. Available from: https://doi.org/10.5205/1981-8963-v13i01a235022p61-69-2019.
7. ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstet Gynecol. [Internet] 2018 May [cited 01/09/2021] ;131(5):e140-e150. Available from: https://journals.lww.com/greenjournal/fulltext/2018/05000/acog_committee_opinion_no__736__optimizing.42.aspx doi: 10.1097/AOG.0000000000002633.
8. Mercer RT. Becoming a mother versus maternal role attainment. In: MeleisAI, editors. Transitions theory. New York : Springer Publishing Company; 2010. p. 94-104.
9. Savage JS. A fourth trimester action plan for wellness. J Perinat Educ. [Internet] 2020 [cited 01/07/2021];29(2):103–12. Available from: https://doi.org/10.1891/J-PE-D-18-00034
10. José M. Como nasce um pai? A transição para a parentalidade [Master's thesis on the Internet]. Universidade de Évora, Escola de Ciências Sociais; 2018. [cited 15/01/2023]. Available from: http://hdl.handle.net/10174/23424.
11. Sequeira A, Pousa O, Barros A, Freitas C, Oliveira I. Execução da técnica dos 5 S para acalmar o recém-nascido. In: Sequeira A, Pousa O, Amaral C, editors. Procedimentos de enfermagem em saúde materna e obstétrica. Lisboa: Lidel; 2020. p. 252–9.
12. Hannon S, Newnham E, Hannon K, Wuytack F, Johnson L, McEvoy E, et al. Positive postpartum well-being: What works for women. Heal Expect. [Internet] [cited 01/07/2023] 2022;25(6):2971–81. Available from: https://onlinelibrary.wiley.com/doi/10.1111/hex.13605
13. Gottlieb L. O cuidar em enfermagem baseado nas forças. Saúde e cura para a pessoa e família. Loures: Lusodidacta; 2016.
14. Gottlieb LN, Gottlieb B. Strengths-based nursing: A process for implementing a philosophy into practice. J Fam Nurs. [Internet] 2017 [cited 20/09/2023];23(3):319–40. Available from: https://journals.sagepub.com/doi/10.1177/1074840717717731
15. Barradas A, Torgal AL, Gaudêncio AP, Prates A, Madruga C, Clara E, et al. Livro de bolso: Enfermeiros especilaistas em saúde materna e obstétrica/parteiras.

[Internet]. Lisboa: OE; 2015. Available from: https://www.ordemenfermeiros.pt/media/8891/livrobolso_eesmo.pdf
16. Vilelas J. O processo de construção do conhecimento. 2nd ed. Lisboa: Edições Sílabo, Lda; 2017.
17. Bardin L. Análise de conteúdo. Lisboa: Edições 70, Lda; 2015.
18. Instituto Nacional de Estatística. Classificação Portuguesa das Profissões 2010 [Internet]. Lisboa: INE; 2011. 485 p. Available from: https://www.ine.pt/xurl/pub/107961853
19. Sharifipour F, Javadnoori M, Moghadam ZB, Najafian M, Cheraghian B, Abbaspoor Z. Primiparous mothers' perception and expectations regarding social support during the postpartum period: A qualitative study. Iran J Nurs Midwifery Res. [Internet]. 2023 [cited 98/07/2023] ;28(1):38–46.
20. Alves ACP, Lovadini VL, Sakamoto SR. Feelings experienced by women during the puerperium. Rev Enferm Atual. In Derme [Internet] 2021 Feb 1 [cited 01/11/2022];95(33):e021013. Available from: https://revistaenfermagematual.com/index.php/revista/article/view/721
21. Agampodi TC, Dharmasoma NK, Koralagedara IS, Dissanayaka T, Warnasekara J, Agampodi SB, et al. Barriers for early initiation and exclusive breastfeeding up to six months in predominantly rural Sri Lanka: a need to strengthen policy implementation. Int Breastfeed J. [Internet]. 2021 Dec [cited 01/07/2021];16, 32. Available from: https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-021-00378-0 https://doi.org/10.1186/s13006-021-00378-0
22. Wong BB, Leow MQH, He H-G. Factors contributing to discontinuation of breastfeeding prior to six month: A mixed-methods study. Singap. Nurs. J. [Internet]. 2021 May [cited 01/11/2022];48(2):2–12. Available from: https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=cul&AN=153516634&lang=pt-pt&site=eds-live&scope=site
23. Zivoder I, Martic-Biocina S, Veronek J, Ursulin-Trstenjak N, Sajko M, Paukovic M. Mental disorders/difficulties in the postpartum period. Psychiatr Danub. [Internet] 2019 Sep [cited 01/07/2021];31(Suppl 3):338-344. Available from: https://www.psychiatria-danubina.com/UserDocsImages/pdf/dnb_vol31_noSuppl%203/dnb_vol31_noSuppl%203_338.pdf
24. Asadi M, Noroozi M, Alavi M. Exploring the experiences related to postpartum changes: perspectives of mothers and healthcare providers in Iran. BMC Pregnancy Childbirth. [Internet]. 2021 Jan 5 [cited 01/11/2022];21(1):7. Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03504-8 https://doi.org/10.1186/s12884-020-03504-8
25. Ayers S, Crawley R, Webb R, Button S, Thornton A, Smith H, et al. What are women stressed about after birth? Birth. [Internet]. 2019 Dec 1 [cited 01/07/2021];46(4):678–85. Available from: https://doi.org/10.1111/birt.12455
26. Brown A, Shenker N. Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support. Matern Child Nutr. [Internet]. 2021 [cited 01/11/2022];17(1):e13088. Available from: https://doi.org/10.1111/mcn.13088
27. Caetano ABJR, Mendes IMMMD, Rebelo Z de ASA. Maternal concerns in the postpartum period: an integrative review. Rev Enferm Ref [Internet]. 2018 Apr [cited 01/11/2022];4(17):149–59. Available from: https://rr.esenfc.pt/rr/index.php?module=rr&target=publicationDetails&pesquisa=&id_artigo=2858&id_revista=24&id_edicao=132 https://doi.org/10.12707/RIV17074
28. Hadjigeorgiou E, Vogazianos P, Christofi MD, Motrico E, Domínguez-Salas S, Mesquita AR, et al. Experiences, concerns, and needs of pregnant and postpartum women during the Covid-19 pandemic in Cyprus: a cross-sectional study. BMC Pregnancy Childbirth. [Internet]. 2022 Dec 1 [cited 01/11/2022];22(1):1–13. Available from: https://doi.org/10.1186/s12884-022-05017-y
29. Joy P, Aston M, Price S, Sim M, Ollivier R, Benoit B, et al. Blessings and Curses: Exploring the Experiences of New Mothers during the COVID-19 Pandemic. Nurs Rep. [Internet]. 2020 Dec 21 [cited 01/11/2022];10(2):207–19. Available from: https://doi.org/10.3390/nursrep10020023
30. Sakalidis VS, Rea A, Perrella SL, McEachran J, Collis G, Miraudo J, et al. Longitudinal changes in wellbeing amongst breastfeeding women in Australia and New Zealand during the COVID-19 pandemic. Eur J Pediatr.[Internet]. 2022 Oct [cited 01/11/2022]; 181(10):3753-3766. Available from: https://doi.org/10.1007/s00431-022-04580-y
31. McLeish J, Harvey M, Redshaw M, Alderdice F. A qualitative study of first time mothers' experiences of postnatal social support from health professionals in England. Women Birth. [Internet]. 2021 Sep [cited 01/11/2022];34(5):e451-e460. Available from: doi: 10.1016/j.wombi.2020.10.012.
32. Oliveira G, Timm MS, Schimith MD, Prates LA, Alves CF, Silva LMC da, Jerke LC. Conhecimento de puérperas sobre o aleitamento materno. Revista Recien [Internet]. 21 dezembro 2022 [cited 08/07/2023];12(40):314-23. Available from: https://recien.com.br/index.php/Recien/article/view/627
33. Rodgers RF, Fischer LE, Zimmerman E. Partner influences, breastfeeding, and body image and eating concerns: An expanded biopsychosocial model. Appetite. [Internet]. 2022 Feb 1 [cited 08/07/2023];169:105833. Available from: doi: 10.1016/j.appet.2021.105833
34. Silva OBM, Bernardino E, Encarnação P, Lima LS, Silva OLS, Rorato C. Strengths-based nursing and healthcare: percepção de mulheres em uma maternidade de risco habitual. Cogitare Enferm [Internet]. 2022 [cited

08/07/2023];27:e78853. Available from: https://doi.org/10.5380/ce.v27i0.78853.