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Original Article

Profile of occupational therapy practice in high-risk obstetric wards and rooming-in units

Perfil da atuação terapêutica ocupacional em enfermaria obstétrica de alto risco e no alojamento conjunto

Caroline Cavalcante Vidal[a], Maria Luísa de Sá Peregrino Arrais[a], Naianna Ribeiro Mocelin dos Santos[a], Juliana Fonsêca de Queiroz Marcelino[a], Raquel Costa Albuquerque[a], Cíntia de Oliveira Castelo Branco Sales[a], Marina Araújo Rosas[a]

[a]Universidade Federal de Pernambuco – UFPE, Recife, PE, Brasil.

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Abstract

Introduction: Pregnancy, childbirth, and the postpartum period are phases of significant changes for both the woman and the neonate. The occupational therapist is involved with a contextualized approach to routines and occupations. **Objective:** To characterize the occupational therapy practice in the High-Risk Obstetric Ward and Rooming-In. **Method:** A descriptive, documentary-type, quantitative study conducted using occupational therapy service records in the patient chart system in 2023. Data collection used an original instrument, and analysis was performed with Microsoft Excel, SPSS, and GraphPad Prism software, utilizing the Chi-square and Fisher's Exact tests. **Results:** A total of 308 services were evaluated. Of the records, 30 (17.5%) were during the pregnancy period, 98 (57.3%) during the postpartum period, 8 (4.7%) during both pregnancy and postpartum, 2 (1.2%) during pregnancy, postpartum, and newborn care, and 33 (19.3%) during postpartum and newborn care. Of the 375 interventions, the most frequent among pregnant women was related to health management occupation (39.2%), while in the postpartum group, it was breastfeeding (33%), and for newborns, it was rest and sleep (60%). Postpartum women showed a greater need for intervention in instrumental activities of daily living (IADL), while pregnant women required support in leisure and social participation occupations. **Conclusion:** Among various interventions, occupational therapy provides maternal-infant support, facilitating occupational performance and health care.

Keywords: Rooming-in Care, Hospitalization, Parenting, Neonatology, Women's Health, Occupational Therapy.

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Resumo

Introdução: A gestação, parto e puerpério são fases de modificações integrais para a mulher e o neonato. A terapeuta ocupacional se insere com atuação contextualizada nas rotinas e ocupações. **Objetivo:** Caracterizar a atuação terapêutica ocupacional na Enfermaria Obstétrica de Alto Risco e Alojamento Conjunto. **Método:** Estudo descritivo do tipo documental de natureza quantitativa, realizado a partir dos registros de atendimento da terapia ocupacional no sistema de prontuários, no ano de 2023. Para coleta de dados utilizou-se instrumento autoral e, para análise, softwares Microsoft Excel, SPSS e Graphpad Prism, utilizando os testes Qui-quadrado e Exato de Fisher. **Resultados:** Foram avaliados 308 atendimentos. Dos registros, 30 (17,5%) foram de acompanhamento no período gestacional, 98 (57,3%) no puerpério, 8 (4,7%) na gestação e no puerpério, 2 (1,2%) nos períodos de gestação, puerpério e atendimento ao recém-nascido, e 33 (19,3%) no puerpério e atendimento ao neonato. Das 375 intervenções, a mais frequente entre gestantes foi referente à ocupação de gestão da saúde (39,2%), enquanto no grupo de puérperas foi a amamentação (33%), e com os recém-nascidos foi descanso e sono (60%). Puérperas apresentaram maior necessidade de intervenção em atividade instrumental da vida diária (AIVD), enquanto gestantes nas ocupações lazer e participação social. **Conclusão:** Entre diversas intervenções, a terapia ocupacional oferece apoio materno-infantil, facilitando o desempenho ocupacional e o suporte à saúde.

Palavras-chave: Alojamento Conjunto, Hospitalização, Maternidade, Neonatologia, Saúde da Mulher, Terapia Ocupacional.

Introduction

Women's Health encompasses the promotion of improving the living conditions and health of women at all stages of their life cycle, ensuring sexual and reproductive rights, as well as other legally constituted rights; and expanding access to means and services for the promotion, prevention, and comprehensive health care throughout the national territory, without any form of discrimination, respecting gender, race, ethnicity, generation, social class, sexual orientation, and women with disabilities (Brasil, 2013).

Pregnancy, childbirth, and the postpartum period are stages that are part of the reproductive period where the woman is exposed to changes, demands, adaptations, and bodily, biochemical, hormonal, familial, and social reorganizations. The changes that occur in this specific period are subjective and unique. Each woman reacts differently to new stimuli and demands, considering that these reactions may depend greatly on the individual and sociocultural context, the circumstances in which the pregnancy occurred, relationships with family members and partners, the repercussions this situation may have triggered, and the occurrence of stressful events (Bortoletti, 2007).

In the 1980s, the *Rede Cegonha* (Stork Network) emerged as the first of five thematic networks for pregnancy, childbirth, and postpartum care. Before it, there was no health program that offered comprehensive care to the pregnant woman and the baby. These changes aim to break the conceptions that consider only the biological and reproductive

aspects of women, responding to calls for changes in the preexisting care model in Brazil, which did not address the needs of this population with the necessary specificity (Vilela et al., 2021).

This strategy was created with the goal of ensuring assistance to women and children so that both can experience the pregnancy-puerperal cycle in a safe, respectful, and dignified manner, as pregnancy and childbirth are not a process of illness but a physiological one, representing a unique experience for the entire family that should be protected (Brasil, 2011). Currently, the network is undergoing a restructuring strategy, with new investments aimed at improving maternal and neonatal mortality rates. To achieve this, the services accompanying this population can count on various healthcare professionals, including occupational therapists.

According to a study by Nascimento et al. (2017), the bodily changes caused by pregnancy influence the execution of occupations. In this regard, the occupational therapist working with the pregnant woman can use various strategies to improve occupational performance. These include body approaches, experience exchanges, health education, activity adaptation, among others, aiming to modify and restore functional capacity and occupational performance in daily life (Martins & Camargo, 2014).

Occupational therapy focuses its approach on participation and occupational engagement, which refers to the subject's ability to perform tasks and activities that allow the fulfillment of occupational roles in a satisfactory, balanced, and appropriate manner. Occupational roles are developed through a set of occupations performed, identified by AOTA in 2021, in its Occupational Therapy Practice Framework, as activities of daily living (ADL), instrumental activities of daily living (IADL), play, leisure, education, work, sleep and rest, social participation, and health management. To intervene in occupations, it can act at various levels of healthcare and populations, including women's health and neonatal health.

After childbirth, the first 24 hours are a vulnerable period for the mother-baby dyad, as it is related to the physiological changes in the woman's postpartum period and the newborn's physiological adjustments to extrauterine life. For this reason, the World Health Organization (Organização Mundial da Saúde, 2022) recommends that, for a positive postnatal experience, the woman-newborn dyad should be the center of care with a minimum stay in the birthing institution. This is a key moment to promote health, identify problems, and support the transition to care for women and babies, extending up to two weeks.

In order to achieve these goals, institutions that provide maternal-infant support seek to adjust their operating model. The *Alojamento Conjunto* (Rooming-In) system is exactly such a model of hospital care with various differentiated requirements. One of the main ones refers to the clinical stability of the mother and newborn, allowing them to stay together with professional support in the same environment, fully incentivizing breastfeeding. When this care model is implemented, the institution is granted the title of *Hospital Amigo da Criança* (Child-Friendly Hospital) (Brasil, 2016). Depending on the level of complexity, maternity hospitals may also be categorized as low or high risk.

The Ministry of Health (Brasil, 2022) defines High-Risk Pregnancy as one where the life or health of the mother and/or fetus and/or newborn are at greater risk than the general population. These factors may be inherent to the pregnancy itself or related to infectious diseases during pregnancy, among other causes tied to morbid conditions. As

a result, these institutions become references for monitoring these pregnant women who face greater care complexity and may present specific demands due to high risk, alongside the typical demands of the pregnancy period. These aspects, both of low-risk and high-risk pregnancies, can be addressed by the occupational therapist to promote health and enhance care.

Still, in the context of the immediate postpartum period, there are demands that may arise specifically depending on the type of delivery. Normally, vaginal birth does not present as many recovery challenges as cesarean sections. Due to the surgical process, these women face recovery obstacles that prevent the full performance of their main occupations immediately after surgery, which can affect the satisfaction of some and diminish their quality of life. Although these difficulties are temporary, they can be monitored by the occupational therapist and facilitated for a favorable recovery or not (Medeiros & Marcelino, 2018).

Associated with childbirth, activities related to newborn care begin, along with changes in the routine. The role a woman occupies in society and in the orchestration of family activities remains, even today, strongly linked to caring for children, her husband, and everything related to domestic life. In the initial period after birth and immediate postpartum, the protagonism of the dyad is present and it is important that it is valued. However, it is also a period strongly shaped by social factors that must be considered to prevent the perpetuation of a culture that presents motherhood as an essential component of being a woman or even an innate phenomenon of femininity (Oliveira et al., 2021).

One of the approaches of occupational therapy in this context concerns the performance of the dyad (mother-baby) as beings who become involved in new activities (Menegat, 2023). The occupations involved in motherhood are built gradually, personally, and intimately. Starting from birth, they have a form, a rhythm, a beginning, and an end, and with cultural meaning. These may include various activities, observable or not directly by external caregivers (such as the professional team), such as comforting, playing, cleaning, looking, talking, reading, protecting, touching, holding, or recording moments, which can then be grouped and related into three main occupations: feeding, hygiene, and baby care (Fraga et al., 2019).

When there is a high-risk pregnancy, the chances of premature or late premature birth increase, which can cause changes and the emergence of new diagnoses in the newborn's clinical condition. Issues such as neonatal jaundice, reflux, hypoglycemia, and incorrect breastfeeding are common and require specific care from the healthcare team (Costa et al., 2015). During this care process, the performance of newborn care occupations may also be compromised, and the occupational therapist can assist in the occupational performance of the dyad. Additionally, they can work directly in neonatal care, considering the newborn's occupations in the context of hospitalization, addressing aspects of the health-disease process that may hinder participation in these activities and promoting neuroprotection, stimulation, and adequate development (Alves & Rabelo, 2022).

In light of all these events, complications, and the possibilities for intervention through specialized care provided by the occupational therapist, occupational therapy can contribute to monitoring within the high-risk obstetric ward and rooming-in. Moreover, the role of this professional in this context has not been widely explored, with few occupational therapists and little dissemination within the technical-scientific

community. Therefore, the objective of this study is to characterize the occupational therapy practice in the high-risk obstetric ward and rooming-in.

Method

This is a descriptive documentary-type study of a quantitative nature, conducted based on occupational therapy service records for patients in rooming-in and high-risk obstetric wards, in the patient chart system of a University Hospital. The service where the research was conducted is located within the institution and operates in an integrated manner.

The care is provided by the same multidisciplinary team that is dedicated to the care of pregnant women, postpartum women, and newborns. Currently, it has 30 beds, 21 allocated to rooming-in (postpartum women and newborns) and 9 to the high-risk obstetric ward (pregnant women). The team consists of 5 obstetricians, 3 neonatologists, 13 nurses, 32 nursing technicians, 1 psychologist, 1 occupational therapist, and 1 social worker, with availability for consultations from speech therapists and physiotherapists – this number can be adjusted depending on the shifts and service demand. Additionally, this professional team includes residents, students, and interns undergoing academic training.

The occupational therapy monitoring is currently offered by the sector's professional, residents, and undergraduate students under supervision. The services are provided Monday through Thursday by the sector's professional, and additionally, during the monthly rotation of residents in the Women's Health Program at the Hospital das Clínicas, some Saturdays and holidays are included.

Inclusion criteria included therapy service records for patients hospitalized in 2023, provided by the NDC (Clinical Documentation Center), by occupational therapists from the service, residents, and academic students during the period from January 2023 to January 2024. Exclusion criteria involved incomplete therapy service records, without a clear objective of service or description of the intervention.

Data collection was carried out from April to August 2024, using the patient records of those hospitalized in rooming-in and high-risk obstetric wards. For data collection, the authors developed a semi-structured questionnaire instrument, based on an international framework that defines and characterizes human occupations within the scope of occupational therapy, titled *Enquadramento da Prática da Terapia Ocupacional: Domínio & Processo* (Framing Occupational Therapy Practice: Domain & Process) produced by AOTA (Gomes et al., 2021).

To define the minimum sample size for the study, the Open Epi program, version 3, a free, open-source tool for descriptive and analytical study statistics, was used. The total population number was established based on the average number of services expected by the occupational therapy service in the ward for one shift (6 services), which was then replicated over a month with 4 weeks (120 services) and a year (1440 services). The number of services provided by residents or undergraduate interns was not included in the sum of these data, considering the unpredictability of services, meaning there is no defined number expected beyond the quantity established by the service. With this number of services, the maximum prevalence estimate (50%), a sampling error of 5%, and a study design effect of 1 were considered, resulting in a confidence interval of 95%, yielding a final study sample of 308 service records.

Data analysis was carried out through the creation of a spreadsheet (Microsoft Excel®, version 2022), where all actions were grouped according to the group in which they were applied (pregnant women, postpartum women, and newborns) in the occupation areas: ADL, IADL, health management, rest and sleep, work, leisure, social participation, and breastfeeding. The interventions in the occupation areas included: education and training, occupation and activity, advocacy, group intervention, individual intervention, and occupational support intervention. After tabulation, the data were exported and analyzed in SPSS software, version 26.0 (IBM Corp, Armonk, NY, USA), and graphs were generated in GraphPad Prism, version 8.0 (GraphPad Software, San Diego, CA, USA). To compare the proportions of occupations and interventions performed, the Chi-square test (or Fisher's exact test, when necessary) was applied, along with the Odds Ratio (OR) test. Conclusions were drawn based on statistically significant differences when $p < 0.05$.

All ethical recommendations were followed according to Resolution No. 466/2012 of the National Health Council, after signing the consent letter and data use authorization form. Additionally, the study was approved by the Research Ethics Committee involving human subjects at the Hospital das Clínicas of the Federal University of Pernambuco with opinion No. 6.753.393.

Results and Discussion

Target audience characterization data

A total of 171 patient records were evaluated, in which a total of 308 attendances and 375 actions (interventions) were found. The age groups of women with the highest concentration in the progress notes were: 36 (21%) aged 20-24 years and 53 (31%) aged 25-29 years. Regarding education level, a total of 44 (25.7%) had incomplete elementary education, 35 (20.5%) had completed elementary education, 76 (44.4%) had completed high school, and 9 (5.3%) had higher education. The educational information for 7 (4.1%) women was not identified. Of the total women served, 78 (45.6%) were primiparas, 91 (53.2%) were multiparas, and 2 (1.2%) had no information on the number of children identified.

Regarding the timing of the service, 30 (17.5%) were followed only during the pregnancy period, 98 (57.3%) only during the postpartum period, 8 (4.7%) during both the pregnancy and postpartum periods, 2 (1.2%) during the pregnancy, postpartum, and with newborn care, and 33 (19.3%) during the postpartum period and with newborn care.

Of the total of 40 pregnant women attended, 1 (2.5%) was in the first trimester of pregnancy, 3 (7.5%) in the second trimester, and 36 (90%) in the third trimester of pregnancy. Of the total of 139 postpartum women attended, 32 (23%) had vaginal births, while 105 (75.6%) had cesarean sections, and 2 (1.4%) patients had no birth data identified.

Regarding the gestational age of the study's neonates, 139 were listed, with 120 (86.3%) being full-term (considering full-term as a gestational age of 37 weeks or more, which defines borderline prematurity) and 12 (20%) preterm. Finally, of the 139 newborns, 50 (36%) had jaundice and required hospitalization for treatment. All the described data are presented in Table 1.

Table 1. Characterization of women and newborns treated by occupational therapy in the High-Risk Obstetric Ward and Joint Accommodation (Recife), 2024.

Characteristics	Patients	
Age (years ± standard deviation)	**27. 9 (± 6.7)**	
	N	%
Age range 10 – 14 years	1	0.6
Age range 15 – 19 years	25	14.6
Age range 20 – 24 years	36	21
Age range 25 – 29 years	53	31
Age range 30 – 34 years	30	17.5
Age range 35 – 39 years	21	12.3
Age range 40 – 45 years	5	3
Education		
Incomplete elementary education	44	25.7
Complete elementary education	35	20.5
High School	76	44.4
Higher education	9	5.3
NI	7	4.1
Number of Children		
Primiparous	78	45.6
Multiparous	91	53.2
NI	2	1.2
Intervention Period		
Pregnancy only	30	17.5
Only postpartum	98	57.3
Pregnancy and postpartum period	8	4.7
Pregnancy, postpartum period and newborn	2	1.2
Puerperium and newborn	33	19.3
Total during pregnancy	40	18.7
Total in the puerperium	139	65.0
Total newborn	35	16.3
Intervention Period in Women Pregnant women		
1st trimester	1	2.5
2nd trimester	3	7.5
3rd trimester	36	90
Birth route		
Normal	32	23
Caesarea	105	75.6
NI	2	1.4
Newborn		
Full-term	120	86.3
Premature	12	8.6
Age of birth not identified	7	5.1
Hospitalization for Jaundice	23	65.7
Number of interventions	375	100
Gestation	74	19.7
Postpartum	281	75
Newborn	20	5.3

NI: Not identified; N: Number of patients treated.
Source: Authors.

A cesarean section is a surgical intervention necessary in specific cases where there is a risk to the life of the woman and the neonate in the context of childbirth. The reasons for its indication are selective and should be performed with great caution. In Brazil, the rates of cesarean births have remained far above the levels recommended by the WHO (Pereira et al., 2024). These data are alarming and should be critically perceived by maternity hospitals. When referring to services that accompany high-risk pregnancies and the number of cesarean births, it is understandable that there is a higher prevalence, as was observed in the data analysis.

A study by Antunes et al. (2020), conducted in a philanthropic hospital contracted by the SUS in southern Brazil, which also follows a profile of high-risk pregnancies, showed similar results to those identified in this research. During the period when their study was conducted, analyzing the relationship between gestational risk and the type of birth, their research results showed that the primary outcomes were cesarean birth (72.8%), spontaneous abortion (0.9%) versus vaginal birth (26.2%).

Quality prenatal care and appropriate assistance save lives. However, it is important to recall that when poorly indicated, cesarean sections can cause infections, neonatal respiratory complications, and increase the risk of maternal and fetal death (Mascarello et al., 2017). Studies also show that it is associated with a high rate of iatrogenic prematurity – which occurs when birth is performed through a medical intervention without clinical indication, such as a scheduled cesarean without justification for interruption, or with an incorrect gestational age (Oliveira & Carmo, 2018).

Another topic identified in the characterization refers to neonates with jaundice. Jaundice, a word derived from Latin – *icterus* – meaning yellow or yellowish, is an abnormal condition that gives a yellowish appearance to the human body. This appearance is caused by an excess of bilirubin. In cases of neonatal jaundice, the primary cause is the incomplete development of the liver machinery and bilirubin excretion. Currently, the main form of treatment in maternity hospitals is through phototherapy, which consists of exposing the neonate's skin to specific lights, using only a diaper and protective glasses (Morais et al., 2023). When the service follows the model of rooming-in, it is the parents and/or mother and accompanying person who manage the newborn with the support of the professional team.

A study by Dias et al. (2022) on factors associated with the need for phototherapy in rooming-in at a service that cares for high-risk pregnant women showed that late preterm newborns in rooming-in had six times the chance of needing phototherapy. Jaundice in these babies is not only more frequent but also more pronounced and prolonged in late preterm infants. This data implies the need for active involvement with postpartum women and newborns by the professionals involved in newborn care to better guide treatment and prevent future complications, such as severe neurological syndrome, among other systemic complications (Bomfim et al., 2021).

Interventions

A total of 375 interventions were analyzed, with 74 (19.7%) of them in pregnant women, 281 (75.0%) in postpartum women, and 20 (5.3%) in newborns (Table 1).

Of the 74 interventions performed during pregnancy, the most frequent area of occupation was health management (39.2%), followed by social participation (17.6%), leisure (14.9%), and ADLs (13.5%). Of the 281 actions performed during the postpartum period, the most frequent was breastfeeding (33%), followed by health management (28.1%), IADLs (19.9%), and ADLs (15.7%). For neonates, the most frequent areas were rest and sleep (60%), followed by breastfeeding (40%).

When comparing the groups of pregnant women and postpartum women in relation to the area of occupation worked on in the interventions, statistically significant differences were found for IADLs, leisure, and social participation. The postpartum group showed a greater need for intervention in IADLs (OR = 8.3; p < 10-4; 95% CI (2.57 – 26.57)), while the pregnant women's group required more interventions in leisure (OR = 7.4; p < 10-4; 95% CI (3.4 – 15.8)) and social participation (OR = 8.4; p < 10-4; 95% CI (3.8 – 18.0)). All the data are detailed in Table 2 and discussed later.

Table 2. Distribution of occupations and interventions by phase of care (Recife), 2024.

Area of occupation	Gestation		Postpartum		Newborn	
Intervention	**N**	**%**	**N**	**%**	**N**	**%**
ADL	**10**	**13.5**	**44**	**15.7**	-	-
Education and Training	8	80	33	75	-	-
Occupation and Activity	-	-	1	2.3	-	-
Occupation and Activity/Education and Training	2	20	10	22.7	-	-
IADL*	**3**	**4**	**56**	**19.9**	-	-
Education and Training	2	66.7	37	66.1	-	-
Occupation and Activity	-	-	3	5.3	-	-
Advocacy	-	-	1	1.8	-	-
Occupation and Activity/Education and Training	1	33.3	15	26.8	-	-
Health Management	**29**	**39.2**	**79**	**28.1**	-	-
Occupation and Activity	1	3.5	2	2.5	-	-
Education and Training	17	58.6	58	73.4	-	-
Group intervention	2	6.9	1	1.3	-	-
Occupation and Activity and Education and Training	4	13.8	17	21.5	-	-
Education and Training and Group Intervention	3	10.3	1	1.3	-	-
Occupation and Activity and Education and Training and Group Intervention	2	6.9	-	-	-	-
Rest and sleep	**6**	**8.1**	**7**	**2.5**	**12**	**60**
Education and Training	5	83.3	5	71.4	-	-
Occupation and Activity	-	-	1	14.3	12	100
Occupation and Activity and Education and Training	1	16.7	1	14.3	-	-
Work	2	2.7	1	0.4	-	-
Occupation and Activity and Education and Training	1	50	1	100	-	-
Occupation and Activity and Education and Training and Group Intervention	1	50	-	-	-	-
Leisure*	**11**	**14.9**	-	-	-	-
Occupation and Activity	6	54.5	-	-	-	-
Group intervention	1	9.1	-	-	-	-
Occupation and Activity and Group Intervention	4	36.4	-	-	-	-
Social participation*	**13**	**17.6**	**1**	**0.4**	-	-
Education and Training	1	7.7	-	-	-	
Occupation and Activity	3	23.1	1	100	-	-
Group intervention	3	23.1	-	-	-	-
Occupation and Activity and Group Intervention	6	46.1	-	-	-	-
Breast-feeding	-	-	**93**	**33**	**8**	**40**
Education and Training	-	-	40	43	-	
Occupation and Activity	-	-	4	4.3	8	100
Group intervention	-	-	1	1.1	-	-
Occupation and Activity and Education and Training	-	-	41	44.1	-	-
Occupation and Activity and Interventions that Support Occupations and Education and Training	-	-	2	2.1	-	-
Occupation and Activity and Education and Training and Group Intervention	-	-	2	2.1	-	-
Occupation and Activity and Interventions that Support Occupations and Education and Training	-	-	3	3.3	-	-

*p < 0.05. ADL: Activities of Daily Living; IADL: Instrumental Activities of Daily Living; N: number of interventions.

Source: Authors.

Based on the aforementioned data, it was possible to conduct specific analyses according to the characteristics of the mentioned audience and the number of interventions by occupation. These will be described below in two sections: maternal care focused on the discussion of services for pregnant women and care for the mother-child duo.

Care for the Pregnant Woman

One of the first data points investigated was that, out of the 171 women attended, 78 were primiparas (45.6%) and 91 were multiparas (53.2%). For the primipara group, there were 179 services (48%), while for the multipara group, there were 194 services (52%).

Out of the 179 services for primiparas, the four main occupations identified were 48 for breastfeeding (26.8%), 47 for health management (26.3%), 29 for Activities of Daily Living (ADLs) (16.2%), and 29 for Instrumental Activities of Daily Living (IADLs) (16.2%). Regarding the multiparas, 194 services were observed, and the four main occupations were 55 for health management (28.3%), 50 for breastfeeding (25.8%), 28 for IADLs (14.4%), and 20 for ADLs (10.3%).

There was no statistically significant difference in the number of services related to occupations between the two groups ($p = 0.55$), nor was there a difference in the type of occupation used in each group. That is, regardless of the number of children, women may require support for their occupational performance. A study by Vivian et al. (2013) pointed out that the arrival of the second child is a new way of experiencing motherhood, sometimes with comparisons between the firstborn, but also with unique distinctions in gestating and giving birth. For each woman, mother, and child, there is a story.

Education was also one of the factors that did not influence the understanding of health management among the women served (Table 1), as the difference between the groups was not statistically significant ($p = 0.366$). We can interpret this aspect by considering the specificity of pregnancy, especially in high-risk pregnancies, which becomes more common for healthcare professionals to understand the management of health processes. That is, a secondary or higher-level education does not necessarily predispose greater knowledge in the areas involved in maternal-infant health. Thus, we can even foresee examples of professionals from other fields of knowledge, such as law, technology, and information, who may present this type of demand due to the distance from their area of expertise.

However, despite this result not being significant, it is important to remember, according to the Technical Manual for High-Risk Pregnancy (Brasil, 2022), that low education can represent a risk factor for pregnancy, as it is linked to less access to information.

In the postpartum period, with cesarean delivery as the mode of birth, alongside the expected physiological aspects of the immediate postoperative period, it was also possible to observe, with the data obtained, a significant impairment in the functionality and occupational performance of the women. Thus, this is an important repercussion, reflecting on the management of various occupations in the first week postpartum.

To interpret this information, we need to consider two important points. First, that these are high-risk pregnancies, with a differentiated complexity in experiencing gestation and birth; second, that they are hospitalized patients, with a context affected by hospitalization.

We can also analyze another previously presented data about the statistically significant difference among some occupations (IADLs, leisure, and social participation) when comparing pregnant women and postpartum women. It is reinforced that the change in the profile of the involved occupations is directly related to the period of hospitalization that these women are going through.

Hospitalization may occur when there is a need for closer support from the healthcare team. However, for a pregnancy to be classified as high-risk, there are some individual characteristics, sociodemographic conditions, previous reproductive history, and clinical conditions prior to pregnancy that may increase the risk of developing pathologies with the potential for maternal-fetal death. The individual and sociodemographic conditions identified as high-risk in the current pregnancy include: age under 15 years or over 40 years; BMI > 40 or low weight at the beginning of pregnancy (BMI < 18); eating disorders such as bulimia and anorexia; and dependence or abuse of tobacco, alcohol, or other drugs.

Regarding the clinical conditions prior to pregnancy that classify the pregnancy as high-risk, we can highlight: chronic hypertension, pre-existing diabetes mellitus, thyroid disorders, bariatric surgery, mental disorders, previous history of thromboembolism, heart disease, hematological disorders, nephropathies, neuropathies, hepatopathies, autoimmune diseases, gynecological conditions, diagnosed cancer, organ transplants, and those living with HIV (Brasil, 2022).

Another factor that can characterize a high-risk pregnancy is the previous reproductive history, including incidents such as: recurrent spontaneous abortion, preterm birth in any previous pregnancy, fetal growth restriction, unexplained fetal death, history of isthmic-cervical insufficiency, Rh isoimmunization, placental accretion, pre-eclampsia, eclampsia, or HELLP syndrome (Brasil, 2022).

In addition to the previous factors and the history of the pregnant woman, other complications can occur and make the pregnancy high-risk, such as in cases of: hypertensive syndromes, fetal growth restriction, fetus above the 90th percentile or suspected macrosomia, oligohydramnios/polyhydramnios, current suspicion of isthmic-cervical insufficiency, suspected placental accretion, placenta previa, hepatopathies, severe anemia or anemia unresponsive to treatment, suspected fetal malformation or arrhythmia, Rh isoimmunization, suspected or diagnosed cancer, mental disorder, and infectious diseases during pregnancy, such as: upper urinary tract infection, syphilis, acute toxoplasmosis, rubella, cytomegalovirus, herpes simplex, tuberculosis, leprosy, hepatitis, and condyloma acuminata (Brasil, 2022).

High-risk pregnant women may go through clinical situations considered obstetric emergencies/urgencies that are grounds for hospitalization, such as: intractable vomiting unresponsive to treatment, severe anemia (Hb ≤7 g/dL), intense and sudden headache, acute asthma attack, acute pulmonary edema, hypertensive crisis (BP ≥160/110 mmHg), premonitory signs of eclampsia and eclampsia/seizures, hyperthermia (axillary temperature ≥37.8 °C) in the absence of signs or symptoms of upper respiratory tract infection, suspected deep vein thrombosis, suspected/diagnosed acute abdomen,

suspected/diagnosed pyelonephritis, ovular infection, gestational pruritus/jaundice, hemorrhages during pregnancy (including premature placental detachment, placenta previa), and gestational age of 41 weeks or more (Brasil, 2022).

High-risk pregnant women, who need to be hospitalized for monitoring or to undergo a procedure, often go through prolonged hospitalizations. This process interrupts the daily activities of both the pregnant woman and her family, often resulting in an abrupt and urgent disruption. Such disruption impacts life, generating a sense of estrangement and making it difficult to become familiar with the environment, to plan for the future, and thus to integrate into the world (Takatori et al., 2004).

According to Ribeiro et al. (2024), when the baby arrives, significant changes occur in the woman and her routine. These are changes in physical, physiological, and emotional adaptations. Feelings of excitement, joy, and relief, but also physical discomfort, fears, and insecurities. It is a period in which the woman continues to need physical and psychological support, as it remains a very delicate time for the mother-child duo, directly influencing the way their relationship may progress. This allows us to look at this period with more attention and understand the particularities that the occupational therapist focuses on when working with both patient profiles.

Care for the Mother-Child Duo

One of the areas with the highest number of interventions was breastfeeding. Of the 78 primiparas followed, 48 (61.5%) required care, while 50 (55%) multiparas were attended. With similar values, the difference was not statistically significant ($p = 0.39$; OR = 0.76; 95% CI (0.42 – 1.44)). From this, we can infer that, with the study population, the act of breastfeeding in multiparous mothers did not become a more independent activity for their performance. This finding aligns with observed aspects that each child, each mother-child duo, behaves in a unique and individualized way. Additionally, it correlates with the profile of high-risk pregnancies, which, due to factors like diabetes and obesity, may interfere with lactation.

Fraga et al. (2019), when studying the construction of what they call "maternal co-occupation" in the neonatal unit, observed that joint involvement and significant, reciprocal engagement between mother and baby generate significant repercussions. Among the activities carried out in the unit that were presented as co-occupations, breastfeeding was included; from the mother's involvement in manually expressing milk and offering a feeding tube, to fully performing the occupation, which is sucking at the breast.

Cardín (2015), when studying the occupational performance of parents of babies in the neonatal unit, also supports this perspective, understanding breastfeeding as a human co-occupation performed by the mother-baby duo. Moreover, breastfeeding should also be included in the understanding of co-occupations and, from this, become one of the lines of care for the occupational therapist working in the neonatal context.

Enquadramento da Prática de terapia ocupacional (the Occupational Therapy Practice Framework) (Gomes et al., 2021) does not include breastfeeding as one of the 9 occupations, but it describes co-occupations as occupations that are frequently shared and done with others, necessarily involving two or more individuals. Thus, even though the co-occupation of breastfeeding is not presented in the description of occupations,

the framework acknowledges the existence of the term, which aligns with what has been studied by authors working in the fields of neonatology and women's health. For this reason, breastfeeding was also included in the data analysis as part of the occupation group.

A study by Vidal et al. (2023) shows that breastfeeding is one of the recurring themes for occupational therapists in Primary Care, not limited to the hospital context of maternal-infant care services. The professionals that make up the Family Health Support team in the municipality under study engage through educational groups about breastfeeding and also related topics, such as baby care and mental health care in the postpartum period. That is, with general health promotion actions or direct facilitation under identified occupational impairment. An important result also identified in the study is that difficulties exist in carrying out the follow-up due to an unstructured or insufficiently structured work process in the healthcare network.

The literature shows us that obstetric variables such as previous experience with breastfeeding, early skin-to-skin contact, use of artificial nipples, and breast anatomy influenced the prevalence of exclusive breastfeeding between the 7th and 10th day postpartum, that is, highlighting that multiparity positively influences exclusive breastfeeding (Pedraza, 2019). However, no studies were identified that provided a focus like the one this research analyzed, considering the first days of life and high-risk pregnant women – who sometimes go through the immediate postpartum period in a different way.

It is a fact that, when analyzing the types of interventions carried out with mother-child duos who received breastfeeding care, 43% (Table 2) was related to education and training for the activity. Observing how the interventions are directed towards managing this co-occupation reinforces the important role occupational therapy has been playing in this context. A study by Pedraza (2019) highlighted that one of the factors influencing breastfeeding rates falling short of expectations was the difficulty or lack of access to information about breastfeeding during prenatal care.

In addition to this analysis, the Postpartum Discharge Guidelines Protocol for Mother-Infant Dyads in Breastfeeding (Hoyt-Austin et al., 2022) emphasizes the importance of a family approach to breastfeeding. This strategy aims to strengthen maternal, paternal/partner, and other family members' support, providing more effective breastfeeding support with a highly significant level of evidence and recommendation.

Even though the participation of this professional in providing support is positive, it is evident that guidance that should have been provided earlier in the hospital period, for example, during primary care, is not reaching all women and ends up being provided during the immediate postpartum period, a time when acquiring information can be challenging, in the first days after birth, and which does not distinguish between multiparous or non-multiparous women.

As presented by Vidal et al. (2023), cited earlier, an article by Tomasi et al. (2017) corroborated the results identified regarding breastfeeding guidance provided during prenatal care. This study was the first to assess aspects of the quality of prenatal care provided in Brazil's primary healthcare network and to investigate potential social inequities. In its discussion, it brought concerning data, one of which was that women from lower-income backgrounds received less guidance during prenatal care, and the

proportion of women who received all the guidance planned for the prenatal period was 60.3%. Of these, breastfeeding guidance was the most provided.

Thus, breastfeeding is a co-occupation and becomes an area of practice for occupational therapy. These professionals have been developing their work in the shared accommodation of this research institution, with this being one of the main intervention focuses. In the same vein of providing guidance, they also focus on training activities, assisting with the management of the breasts and the neonate. Furthermore, it is important to emphasize that breastfeeding is not solely about maternal skills and information; it also requires the other occupational being to be performed: the baby.

Of the 20 actions carried out with the neonate, the main ones were breastfeeding (40%) and rest and sleep (60%). The occupational profile of the newborn consists of activities that mostly require another person to be performed, with the largest proportion in the routine being feeding (breastfeeding), rest and sleep, social participation, and playing. Because of this, the newborn's occupational repertoire is naturally more restricted and gradually gains new occupations as their human development and maturity progress. However, proportionally, if there is difficulty in managing any of their occupations, there is a significant risk of disrupting the routine, which can influence the performance of other activities (Alves & Rabelo, 2022).

According to the same authors, babies who have difficulty feeding/breastfeeding may also have trouble engaging in sleep because they are not fully satiated. With low sleep engagement, they wake up quickly and become frustrated, adopting an irritated behavior. With irritation, it becomes harder for caregivers to manage hygiene, and so on. This also occurs if the baby is in a stressful environment that hinders their transition between alert states gradually, meaning abrupt transitions, which influence their overall behavioral state and consequently their occupational performance.

Because of these aspects, the management of care for the neonate (RN) in phototherapy presents various challenges, including maintaining a calm or sleeping behavioral state to stay exposed to the light; orchestrating the newborn's feeding; changing diapers, among all the other necessary activities. Sometimes, as exemplified, some newborns show a behavioral window that makes them more hyper-responsive, making it difficult for the parents to manage. This aspect was one of the findings highlighted in the research.

Neonates who were hospitalized for phototherapy had mothers who required more care to support their performance in health management. In total, there were 50 neonates (36%) undergoing phototherapy and 89 (64%) who did not require hospitalization. Of these 50 neonates, 42 mothers (84%) received care directed towards the neonatal phototherapy management. Thus, there was a statistically significant difference ($p < 10\text{-}3$; OR = 7.38; CI 95% (3.17-16.67)) in this quantity of care, which reveals a significant role for the occupational therapist as a reference professional to assist in managing the related demands.

Understanding the occupation of health management according to the Occupational Therapy Practice Framework (Gomes et al., 2021) as activities related to the development, management, and maintenance of health and wellness routines, including self-management, with the goal of improving or maintaining health to support

participation in other occupations, we can infer that it also pertains to the care provided by parents in managing phototherapy within the context of rooming-in. It differs from Instrumental Activities of Daily Living (IADL) in caring for others in that the management of phototherapy directly impacts the neonate's health status.

Postpartum women with premature infants in rooming-in also had a higher number of interventions. Of the 139 births mentioned, 120 (86.3%) were full-term deliveries, while 12 (8.6%) were preterm, and the mothers who had preterm births received more care in the IADL of caring for others ($p = 0.028$; OR = 4.83; CI 95% (1.19-17.05)). This data shows us that there are specific demands involving prematurity, in which the occupational therapist worked alongside the mother-infant dyad.

Prematurity presents several important factors to consider, from physiological maturation, the specific care needs of neonates, and also the surprise of the family with the early birth. Furthermore, it is necessary to have a differentiated perspective on the distinct demands that the context requires. Unlike a full-term neonate, the premature infant has specific care needs, regardless of the unit they are being cared for in (e.g., Intensive Care Unit or rooming-in ward). Occupational therapy is one of the professions that works in this context, for example, focusing on the development of the preterm infant through early stimulation to assist in acquiring age-appropriate capacities and skills (Amarante et al., 2021).

Strategies Used in Care

Occupational therapists understand a strategy as a planning process based on a thorough assessment of the patient's capabilities, needs, and life context, encompassing physical, emotional, social, and environmental aspects. The strategy is used to achieve therapeutic goals through the selection of activities or adaptations that promote rehabilitation or the development of the individual's functional abilities. Thus, the strategy is a planned, adaptable, and patient-centered approach that aims to maximize their active participation in daily activities, regardless of temporary or permanent limitations (Gomes et al., 2021). The main strategies identified in this study are listed in Table 3.

Evidence-based practice helps in decision-making that ranges from therapeutic occupational diagnosis, through professional reasoning, to the intervention plan and strategies to be used. Its use by health professionals constitutes a coherent, safe, and systematized way to provide higher quality care and optimize resources, achieving efficacy and a positive cost-benefit relationship in healthcare delivery (Schneider et al., 2020). In this sense, the strategies adopted to manage each clinical case are defined by the professional who is overseeing the case based on their technical knowledge and individualized analysis.

The present study aimed to describe the main interventions and strategies used by occupational therapists in the area in question. However, it is important to emphasize that what is presented in this research should only be applied by properly qualified occupational therapists, following a professional evaluation, considering the uniqueness of their practice context, and always reconciling the scientific evidence regarding its use in professional care.

Table 3. Distribution of occupations and occupational therapy strategies in the High-Risk Obstetric Ward and Rooming-In. (Recife).

OCCUPATIONS	STRATEGIES		
	Gestation	**Postpartum**	**Newborn**
ADL	Performance guidelines, activity training, task adaptation, guidance and training of the companion	Performance guidelines, activity training, task adaptation, equipment adaptation, guidance and training of the companion	-
IADL	Educational groups for newborn care	Management of the support network, training in newborn care activities, guidance on early stimulation, provision of information booklets on child development	-
Health Management	Educational groups on health care, psychoeducation, family and reproductive planning, referrals to health services	Performance guidelines, activity training, task adaptation, equipment adaptation, provision of information booklets, support for newborn care in phototherapy, referrals to health services	-
Sleep and Rest	Sleep hygiene	Sleep hygiene	Neuroprotection, and multisensory stimuli to increase or decrease alertness level, bed positioning
Work	Planning for readjustment of function and routine in the postpartum period, guidance on labor rights	Planning for readjustment of function and routine in the postpartum period, guidance on labor rights, referral to social services	-
Leisure	Providing resources such as games and artistic materials, planning and cultural experiences	-	-
Social participation	Gestational painting, use of collaborative games, group activities	-	-
Breast-feeding	-	Massage, milking, support in breast management, application of tapping, creation of assistive technology, positioning adjustment, performance of translactation	Sensory stimulation to increase alertness, positioning adjustment

ADL: Activities of Daily Living; IADL: Instrumental Activities of Daily Living.
Source: Authors.

Final Considerations

Based on the findings of the present study, we conclude that the main groups served by occupational therapy professionals are mothers aged between 25 and 29 years, pregnant women with prolonged hospitalization, neonates undergoing phototherapy (treatment for jaundice), and mother-infant dyads with difficulty in the co-occupation of breastfeeding.

The interventions performed were focused on the occupational performance of the targeted groups, primarily in IADL Care for Others, Breastfeeding, and Health Management. The strategies were diverse, including individual and group sessions, activity training, guidance, and the production of equipment and products. All of these strategies were used to improve the occupational performance of the patients being served.

Occupational therapy within rooming-in and high-risk obstetric wards plays a role in maternal-infant support for pregnant women, postpartum women, and neonates. These professionals contribute to strengthening women in performing their occupations across different contexts, favoring actions for the promotion of expanded health.

The study presented limitations regarding the writing and characterization of the professional practice of occupational therapy within its respective context. This is due

to the lack of standardization of concepts and terminology previously established in the occupational therapy literature. Aspects involving the interpretation of co-occupations, care activities, and health management were less explored in the literature; however, they become indispensable for the context of this article.

Considering the presented aspects, it is suggested that more research be conducted in the maternal-infant area to recognize and strengthen, with evidence-based practice, the work of occupational therapists with pregnant women, postpartum women, and neonates.

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Author's Contributions

Caroline Cavalcante Vidal was responsible for the study design, data collection, organization, and analysis, writing the discussion paper, and reviewing the text. Cíntia de Oliveira Castelo Branco Sales was responsible for the guidance throughout all stages, data analysis, and reviewing the article until the final version. Marina Araújo Rosas was responsible for the guidance throughout all stages, data analysis, and reviewing the article until the final version. Naianna Ribeiro Mocelin dos Santos was responsible for the conceptualization, data analysis, writing the discussion paper, and reviewing the text. Maria Luísa de Sá Peregrino Arrais was responsible for the data analysis, writing the discussion paper, and reviewing the text. Juliana Fonsêca de Queiroz Marcelino was responsible for the data analysis, writing the discussion paper, and reviewing the text. Raquel Costa Albuquerque was responsible for the data analysis, writing the discussion paper, and reviewing the text. All authors approved the final version of the text.

Data Availability

The data that support the findings of this study are available from the corresponding author, upon reasonable request.

Corresponding author

Caroline Cavalcante Vidal
e-mail: carolinecvidal.to@gmail.com

Section editor

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