Predictors of Acceptance of a Postpartum Public Health Nurse Home Visit

Findings from an Ontario Survey

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ABSTRACT

Objectives: To determine 1) rates of offer and uptake of a home visit provided through Ontario's universal Hospital Stay and Postpartum Home Visiting Program, and 2) predictors of acceptance of a home visit.

Methods: Women were eligible to participate if they had given birth vaginally to a live singleton infant, were being discharged with the infant to their care, were competent to give consent, and could communicate in one of the four study languages. A self-report questionnaire was used to collect data from 1,250 women recruited from five hospitals across the province; 890 (71.2%) women completed a structured telephone interview 4 weeks following discharge.

Results: Most women (81.4% to 97.8%) reported having received a telephone call from a public health nurse, although not necessarily within 48 hours of discharge. While the offer of a home visit reportedly was high across sites, there were statistically significant differences in rates of acceptance (40.8% to 76.2%). Important predictors of acceptance were first live birth, lower social support, lower maternal rating of services in labour and delivery, poorer maternal self-reported health, probable postpartum depression, lower maternal rating of services on the postpartum unit, and breastfeeding initiation.

Conclusion: The home visiting component of the universal program is reaching most women through telephone follow-up. However, rates of acceptance of a home visit differed greatly across study sites. The findings suggest that it is women with specific problems or needs who are accepting a visit. Further research is necessary to guide the development of evidence-based programs and policies regarding postpartum nurse home visits.

MeSH terms: Postpartum women; postpartum programs; nursing, public health; home visits

La traduction du résumé se trouve à la fin de l'article.

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Postpartum home visits by public health nurses generally include assessment of the mother and her newborn infant, education regarding infant care and self-care, provision of support, breastfeeding assistance, and referral to other resources as appropriate. These visits are particularly important given decreasing lengths of postpartum stay in hospital and, as a result, reduced time available for in-hospital support and education. Public health nurse postpartum home-visiting programs vary across Canada but are available to women in most parts of the country. In 1998, Ontario introduced the universal Hospital Stay and Postpartum Home Visiting Program, which provides all new mothers with a public health telephone call within 48 hours of discharge and the offer of a home visit.

Many studies of postpartum nurse home visits have examined visiting programs for women with known risk factors.¹⁻⁴ In two reviews of the intervention literature on nurse home visits to maternal-child clients with multiple risk factors (e.g., adolescent parenthood, single parenting, low income, lack of social support), it was noted that a range of problems can be successfully addressed through home-visiting interventions.^{5,6} Few studies of home visits to the general postpartum population have been published. A Canadian study found that routine visits by public health nurses within 10 days of early postpartum discharge were no more effective than a screening call in terms of breastfeeding rates, gains in maternal confidence or infant medical problems in the early postpartum period.⁷ In another study, conducted in the United States, routine follow-up by nurses in the home within 72 hours of early hospital discharge produced no statistically significant differences in clinical outcomes compared with hospital-based follow-up.⁸ In both studies, the costs of home visits were considerably higher than were costs for the alternate form of follow-up.

Although the evidence suggests that selective provision of postpartum home visits might be the most cost-effective approach to service delivery, it has been argued that targeting health services to those at high risk would leave untouched a significant burden of health and social problems.⁹ No studies have investigated

the characteristics of women who accept postpartum nurse home visits when universally offered. Therefore it is not known whether the uptake of such visits is associated with specific problems, in which case the importance of universal services would be supported. In this paper, we report the findings of a study that examined, in part, the offer, uptake and predictors of acceptance of a postpartum home visit provided through Ontario's Hospital Stay and Postpartum Home Visiting Program.

METHODS

Study design

The data presented in this paper were collected as part of a cross-sectional survey conducted in Ontario, Canada. Its purpose was to examine health outcomes, service use, and costs of care for women and their newborn infants in the first 4 weeks following postpartum hospital discharge.

Sample

A total of 1,250 women were recruited from five hospitals across the province (250 women per site) between October

TABLE I
Characteristics of Study Sites

Site	Characteristics
1	Suburban teaching centre, metropolitan catchment area, 3900 annual births
2	Central east regional centre, urban and rural catchment areas, 1500 annual births
3	Central south regional centre, urban and rural catchment areas, 4500 annual births
4	Urban teaching hospital, metropolitan catchment area, 2700 annual births
5	Central north regional centre, urban and rural catchment areas, 2000 annual births

2001 and August 2002. The hospitals were purposefully selected to provide a diverse sample of women with access to varying services in the community (see Table I). Women were eligible to participate if they had given birth vaginally to a live singleton infant, were being discharged with the infant to their care, were competent to give consent, and could communicate in one of the four study languages (English, French, Chinese and Spanish). Ethics approval was obtained from McMaster University and each of the participating hospitals.

Data collection

Women completed a self-report questionnaire in hospital that captured socio-demographic characteristics and also asked about maternal and infant medical problems since delivery, care providers, infant feeding, maternal concerns, and perceived

adequacy of help and support at home. At 4 weeks following hospital discharge, women participated in a structured telephone interview administered by trained interviewers. The interview schedule included questions about length of stay, health indicators, and satisfaction with services. It incorporated the Edinburgh Postnatal Depression Scale,^{10,11} the Duke-UNC Functional Social Support Questionnaire,¹² and the Health and Social Services Utilization Questionnaire¹³ modified for use with a postpartum population.

Data analysis

Data were entered and analyzed using SPSS 12.0. Descriptive statistics were used to portray participant characteristics and implementation and uptake of postpartum home visiting. Frequency counts and percentages or means and standard deviations

TABLE II
Characteristics of Study Participants (n=1250)

Characteristic	Site (n=250)				
	1	2	3	4	5
Maternal age in years (mean $\pm$ SD)*	31.7 $\pm$ 4.9	28.8 $\pm$ 5.1	29.3 $\pm$ 5.2	29.7 $\pm$ 5.7	27.0 $\pm$ 5.1
Gestation in weeks (mean $\pm$ SD)	39.5 $\pm$ 1.4	39.7 $\pm$ 1.4	39.7 $\pm$ 1.4	39.4 $\pm$ 1.7	39.4 $\pm$ 1.3
Birthweight in grams (mean $\pm$ SD)*	3344 $\pm$ 452	3525 $\pm$ 516	3564 $\pm$ 485	3404 $\pm$ 682	3517 $\pm$ 557
	%	%	%	%	%
Marital status†					
Married	88.8	71.3	79.9	78.3	59.3
Common-law/living with partner	6.0	21.9	14.5	12.3	27.8
Never married/separated/widowed/divorced	5.2	6.9	5.6	9.4	12.9
Family income‡					
<\$20,000	12.1	14.7	7.4	28.5	23.8
\$20,000 to \$39,999	18.2	20.7	13.0	18.4	19.7
\$40,000 to \$59,999	17.3	29.7	23.4	16.7	18.8
\$60,000 to \$79,999	16.0	17.2	22.1	13.6	17.0
$\geq$ \$80,000	36.4	17.7	34.2	22.8	20.6
Born in Canada†	37.6	93.6	81.1	34.1	96.8
Self-reported ethnicity†					
Canadian	26.9	94.3	79.2	37.0	93.6
Other than Canadian§	73.1	5.7	20.8	63.0	6.4
Language spoken at home†					
English/French	55.2	99.6	86.0	63.9	99.6
Other than English/French	44.8	0.4	14.0	36.1	0.4
Highest level of education†					
Less than high school	4.5	9.7	11.6	17.1	13.4
High school	9.7	13.3	14.1	20.8	10.2
Some community college/technical school	5.3	14.5	10.4	8.6	13.4
Completed community college/technical school	19.8	33.5	24.1	17.6	29.7
Some university	10.1	5.6	9.6	6.9	5.3
Completed university	50.6	23.4	30.1	29.0	28.0

* ANOVA indicated a statistically significant difference across sites ($p < 0.05$)

† Chi-square test indicated a statistically significant difference across sites ($p < 0.05$)

‡ 8.4% of the total sample did not report family income

§ At Site 1, 26.9% of the sample was Chinese, 15.5% Jewish; at Site 4, 11.9% of the sample were South Asian

|| At Site 1, 23.6% of the sample spoke Chinese at home; at Site 4, there was no predominant other language

TABLE III
Implementation and Uptake of the Postpartum Home Visiting Program (n=890)

	Site 1 (n=171) %	Site 2 (n=186) %	Site 3 (n=207) %	Site 4 (n=173) %	Site 5 (n=153) %
Received a phone call within 48 hrs of discharge*	74.0	75.0	64.2	71.7	80.0
Received a phone call at all*	88.8	97.8	87.8	81.4	94.7
Offered a home visit†	95.3	91.5	96.6	95.6	94.4
Accepted a home visit*‡	76.2	44.7	40.8	72.1	65.9

* Chi-square test indicated a statistically significant difference across sites ($p < 0.05$)

† Offer is reported for those who received a phone call

‡ Acceptance is reported for those offered a home visit

were calculated as appropriate. Characteristics of women who completed the telephone interview were compared with those who were lost to follow-up at 4 weeks. Chi-square analyses and t-tests were used, as appropriate, to look for statistically significant differences between these two groups. Chi-square analyses were used to determine differences across sites in implementation and uptake of the home-visiting program, and to determine which variables (selected *a priori*) were statistically associated with acceptance of a nurse home visit. Corresponding p-values, odds ratios, and 95% confidence intervals for the odds ratios were calculated for each of these variables. Logistic regression analysis was then used to identify the most important predictors of accepting a visit. Only variables that were found to be statistically significant in the univariate analyses or were judged to be clinically relevant were included in the logistic regression. These results are reported as adjusted odds ratios (OR) and 95% confidence intervals. The criterion for statistical significance was set *a priori* at $\alpha = 0.05$. The goodness of fit of the logistic regression model was assessed using the rho-square statistic and Hosmer and Lemeshow Goodness-of-fit test.

RESULTS

The characteristics of the 1,250 women recruited into the study are presented in Table II. A total of 890 study participants (71.2%) completed the telephone interview at 4 weeks post-discharge. There were no statistically significant differences between women that took part in the interview and women lost to follow-up in terms of any of the variables included in Table II.

The vast majority of study participants across the five study sites (81.4% to

97.8%) reported having received a telephone call from a public health nurse, although not necessarily within 48 hours of discharge from hospital (Table III). While the offer of a home visit reportedly was high across sites, there were statistically significant differences in acceptance of a visit (Table III): between 40.8% and 76.2% of women offered a home visit accepted one.

Nine variables measured prior to hospital discharge and 10 variables measured at 4 weeks after discharge were found to be associated with acceptance of a public health nurse visit (Table IV). When these 19 variables were entered into a logistic regression analysis along with the other 6 variables in Table IV that were justified on the basis of their clinical relevance, 7 factors were determined to be the most important predictors of uptake of a home visit: first live birth, lower social (confidant) support, lower maternal rating of services in labour and delivery, poorer maternal self-reported health after discharge, Edinburgh Postnatal Depression Scale score ≥ 12 (indicating probable postpartum depression), lower maternal rating of services on the postpartum unit, and breastfeeding initiation (Table V).

CONCLUSION

There were high rates overall for implementation of telephone follow-up, which is part of the home visiting component of the Hospital Stay and Postpartum Home Visiting Program. It therefore is reaching most women at some point after their discharge from hospital, albeit not necessarily in a timely manner. However, rates of acceptance of a home visit differed greatly from site to site. The findings regarding variables associated with acceptance of a home visit suggest that women with specif-

ic problems or needs are using this universal service. It may be that these women are self-selecting to take advantage of nurse home visits and/or that nurses are encouraging women they perceive to be at risk to accept a home visit.

The specific problems or needs revealed by our findings are related to socio-demographic characteristics (age, language spoken at home, ethnic/cultural group, place of birth, marital status, family income, education), obstetrical/health factors (first live birth, infant and maternal medical problems after delivery, poorer maternal self-reported health status and lower rating of infant's health after discharge, postpartum depression, breastfeeding), psychosocial issues (concerns prior to discharge, inadequacy of help and support at home, unmet learning needs, lower confidant and affective social support, inability to tell when infant is sick), lack of access to other resources (no family physician, hospital length of stay ≤ 60 hours), and dissatisfaction with health services (lower rating of services in labour and delivery and on the postpartum unit).

The seven variables found to be the most important predictors of acceptance of a public health nurse home visit indicate particular circumstances that perhaps generate the greatest needs.

Four of the variables fall in the domain of obstetrical/health factors (first live birth, poorer self-reported health status, probable postpartum depression, breastfeeding). First time mothers often are unprepared for parenthood and rely on support from family, friends and health professionals.¹⁴ Public health nurse visits can be particularly valuable to inexperienced mothers as visits include teaching, role modelling, encouragement, counselling, and problem solving.¹⁵ Poorer self-reported health status may be related to physical and/or mental health concerns. It is not uncommon for postpartum women to experience physical health problems¹⁶ or postpartum depression.¹⁷ Women may turn to public health nurses for advice regarding these concerns or, in the case of postpartum depression, women may be reaching out for help because they are feeling distressed.¹⁸ Many breastfeeding mothers are not prepared to experience difficulties, even though problems such as anxiety over breast milk sufficiency, painful nipples and an unsettled

TABLE IV

Variables Associated with Acceptance of a Public Health Nurse Home Visit (n=737)

Variables		Accepted a Home Visit Yes N (%)	No N (%)	P value*	Unadjusted Odds Ratio	95% Confidence Interval
Information Collected From Mother Prior to Discharge From Hospital						
Age of mother (n=737):	20-39	400 (57.7)	293 (42.3)		1.00	—
	16-19 or 40-46	32 (72.7)	12 (27.3)	0.050	1.95	(0.99, 3.86)
First live birth (n=735):	No	200 (49.0)	208 (51.0)		1.00	—
	Yes	231 (70.6)	96 (29.4)	<0.001	2.50	(1.84, 3.40)
Has a family physician (n=735):	Yes	406 (58.2)	292 (41.8)		1.00	—
	No	25 (67.6)	12 (32.4)	0.258	1.50	(0.74, 3.03)
Baby had medical problems since birth (n=736):	No	377 (59.3)	259 (40.7)		1.00	—
	Yes	55 (55.0)	45 (45.0)	0.419	0.84	(0.55, 1.28)
Number of concerns prior to discharge† (n=737)	One or fewer	207 (50.6)	202 (49.4)		1.00	—
	Two or more	225 (68.6)	103 (31.4)	<0.001	2.13	(1.57, 2.89)
Mother had medical problems since birth (n=736):	No	393 (57.6)	289 (42.4)		1.00	—
	Yes	39 (72.2)	15 (27.8)	0.036	1.91	(1.034, 3.54)
Language spoken most often at home (n=737):	English/French	348 (56.8)	265 (43.2)		1.00	—
	Other	84 (67.7)	40 (32.3)	0.024	1.60	(1.06, 2.41)
Ethnic or cultural group (n=731):	Canadian	270 (53.8)	232 (46.2)		1.00	—
	Other	157 (68.6)	72 (31.4)	<0.001	1.87	(1.35, 2.61)
Place of birth (n=736):	Canada	287 (55.0)	235 (45.0)		1.00	—
	Other	145 (67.8)	69 (32.2)	0.001	1.72	(1.23, 2.40)
Marital status (n=730):	Partnered	392 (57.6)	289 (42.4)		1.00	—
	Not partnered	34 (69.4)	15 (30.6)	0.105	1.67	(0.89, 3.13)
Total income before taxes and deductions of all household members (n=679):	≥\$20,000	327 (57.2)	245 (42.8)		1.00	—
	<\$20,000	76 (71.0)	31 (29.0)	0.007	1.84	(1.17, 2.88)
Highest level of education (n=732):	Completed high school or less	95 (55.9)	75 (44.1)		1.00	—
	Education beyond high school	335 (59.6)	227 (40.4)	0.387	1.17	(0.83, 1.65)
Mother feels that help and support at home will be adequate (n=734):	Probably or definitely yes	388 (57.6)	286 (42.4)		1.00	—
	Don't know/Probably or definitely not	43 (71.7)	17 (28.3)	0.034	1.86	(1.04, 3.34)
Information Collected from Mother Four Weeks After Discharge from Hospital						
Length of stay (n=737):	≤60 hours	366 (56.9)	277 (43.1)		1.00	—
	>60 hours	66 (70.2)	28 (29.8)	0.015	1.78	(1.12, 2.85)
Length of stay (n=737):	≤48 hours	311 (57.9)	226 (42.1)		1.00	—
	>48 hours	121 (60.5)	79 (39.5)	0.526	1.11	(0.80, 1.55)
Number of unmet learning needs while in hospital (n=737):	<2	133 (47.5)	147 (52.5)		1.00	—
	≥2	299 (65.4)	158 (34.6)	<0.001	2.09	(1.54, 2.83)
Mother's overall rating of hospital labour and delivery services (n=736):	Excellent/Good	391 (57.2)	292 (42.8)		1.00	—
	Fair/Poor	40 (75.5)	13 (24.5)	0.009	2.30	(1.21, 4.37)
Mother's overall rating of hospital postpartum unit services (n=732):	Excellent	137 (47.6)	151 (52.4)		1.00	—
	Good/Fair/Poor	292 (65.8)	152 (34.2)	<0.001	2.12	(1.56, 2.87)
Mother's rating of her own health since having the baby:	Excellent/Very good	225 (52.6)	203 (47.4)		1.00	—
	Good/Fair/Poor	206 (66.9)	102 (33.1)	<0.001	1.82	(1.35, 2.47)
Confidant support‡ (n=729):	20-25	288 (53.5)	250 (46.5)		1.00	—
	5-19	138 (72.3)	53 (27.7)	<0.001	2.26	(1.58, 3.24)
Affective support‡ (n=732):	12-15	372 (56.4)	288 (43.6)		1.00	—
	3-11	56 (77.8)	16 (22.2)	<0.001	2.71	(1.52, 4.82)
Edinburgh Postnatal Depression Scale score (n=731):	<12	374 (56.5)	288 (43.5)		1.00	—
	≥12	52 (75.4)	17 (24.6)	0.002	2.36	(1.33, 4.16)
Mother's rating of infant's health since discharge (n=735):	Excellent/Very good	361 (56.8)	275 (43.2)		1.00	—
	Good/Fair/Poor	69 (69.7)	30 (30.3)	0.015	1.75	(1.10, 2.77)
Mother can tell when baby is sick (n=734):	Yes, most of the time	316 (55.1)	258 (44.9)		1.00	—
	Sometime/No/Don't Know	113 (70.6)	47 (29.4)	<0.001	1.96	(1.35, 2.86)
Any form of breastfeeding initiated (n=732):	No	50 (50.5)	49 (49.5)		1.00	—
	Yes	379 (59.9)	254 (40.1)	0.078	1.46	(0.96, 2.24)

* Chi-square test

† Concerns included: breastfeeding; bottle feeding; infant care and behaviour; signs of illness in infant; physical changes and care of self; sexual changes and intercourse; emotional changes in self; family changes.

‡ From The Duke-UNC Functional Social Support Questionnaire⁶

baby are common.¹⁹⁻²¹ Public health nurses are an essential source of breastfeeding assistance and/or advice for many new mothers.

One psychosocial variable, low confidant support, was another main predictor of acceptance of a home visit. Confidant support reflects a relationship in which important life concerns can be discussed.¹² When confidant support is absent in a woman's social environment, the public health nurse might be someone with

whom a woman can share her postpartum concerns. Finally, dissatisfaction with services, both in labour and delivery and on the postpartum unit, predicted acceptance of a home visit. Patient satisfaction is "a health care recipient's reaction to salient aspects of the context, process, and result of their service experience" (p. 189).²² As such, it may be that women's dissatisfaction is related to not having needs adequately met as part of their in-hospital experience. Public health nurses might

then be an especially important resource following discharge.

The strengths of this study include: the large, diverse sample recruited from purposefully selected varied settings; the inclusion of women who speak languages other than English; the incorporation of reliable and valid measurement tools in the research instruments; and the use of an established and proven research process.²³ The generalizability of the findings, however, may be somewhat limited by the use

TABLE V

Final Logistic Regression Model of the Most Important Predictors of Accepting a Public Health Nurse Home Visit during the First 4 Weeks Following Hospital Discharge (n=716)

Predictors	Adjusted Odds Ratio*	95% Confidence Interval
First live birth†:		
No	1.00	—
Yes	2.69	(1.94, 3.73)
Confidant support score‡:		
20-25	1.00	—
5-19	2.05	(1.38, 3.04)
Mother's overall rating of hospital postpartum unit services:		
Excellent	1.00	—
Good/Fair/Poor	1.69	(1.21, 2.34)
Mother's rating of her own health since discharge:		
Excellent/Very good	1.00	—
Good/Fair/Poor	1.47	(1.05, 2.05)
Edinburgh Postnatal Depression Scale score:		
<12	1.00	—
≥12	2.10	(1.14, 3.88)
Mother's overall rating of hospital labour and delivery services:		
Excellent	1.00	—
Good/Fair/Poor	2.22	(1.06, 4.63)
Any form of breastfeeding initiated:		
No	1.00	—
Yes	1.65	(1.04, 2.61)

Final Logistic Regression Model Statistics:

Rho-square = 0.10 (a pseudo R², values between 0.2 and 0.4 suggest a very good fit)

Hosmer and Lemeshow Goodness-of-fit test = 0.33 (values greater than 0.25 indicate good fit)

66.8% correctly classified

* Odds ratios for categorical variables represent comparisons with the referent group (OR=1.00) after adjustment for all other variables in the model

† Information collected from mother prior to discharge from hospital

‡ From The Duke-UNC Functional Social Support Questionnaire⁶

of a sample of medically low-risk mothers and infants following vaginal delivery and the lack of psychometric testing of the complete study instruments. Logistic regression was used to identify the most important predictors of a public health nurse home visit while adjusting for other variables. Although all the variables in Table V are statistically significant and represent the most important predictors of a public health nurse home visit (based on the information collected), the magnitude of the odds ratios may be somewhat inflated since odds ratios typically overestimate relative risks when the occurrence of an event is not rare.

Future studies should explore characteristics of women who accept selective vs. universal nurse home visits, reasons women accept a visit, and the extent to which their needs are met. Although study findings have shown no difference in outcomes when comparing different types of postpartum follow-up,^{7,8} there is a need for more research that examines the effectiveness of different approaches to postpartum follow-up in relation to achieving desired health outcomes. In particular, studies that examine the effectiveness of less costly telephone follow-up compared to home visitation are warranted. The dose and intensity

of the intervention (i.e., number and frequency of contacts) required to achieve an effect²⁴ and costs should be assessed. Finally, studies should address causal explanations as to how various theoretically-based interventions specific to addressing problems of interest lead to desired outcomes.^{5,24}

The findings of our study lend support for universal public health nurse postpartum visits. As noted by Elkan et al.,⁹ there is no effective means of predicting where and when problems will occur, and universal services might reach clients with specific needs who otherwise would not seek out care. However, because home visits are costly, it is important that they be carefully planned and implemented to effectively meet the diverse needs of women. Ongoing research in the area of nurse home visiting and other approaches to follow-up is essential to the development of evidence-based programs and policies oriented towards postpartum women and their infants.

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RÉSUMÉ

Objectifs : 1) Déterminer l'offre et la demande des visites à domicile fournies par l'entremise d'un programme universel de l'Ontario appelé *Hospital Stay and Postpartum Home Visiting Program*, et 2) cerner les variables prédictives de l'acceptation, par les mères venant d'accoucher, d'une visite à domicile.

Méthode : Le programme s'adressait aux femmes ayant accouché par voie vaginale d'un bébé unique né vivant, ayant reçu leur congé de l'hôpital avec leur nourrisson, capables de donner un consentement, et pouvant communiquer dans l'une des quatre langues de l'étude. Au moyen d'un questionnaire d'auto-évaluation, nous avons recueilli des données auprès de 1 250 femmes recrutées dans cinq hôpitaux de la province; 890 femmes (71,2 %) ont répondu à une entrevue téléphonique semi-structurée quatre semaines après leur sortie de l'hôpital.

Résultats : La plupart des femmes (entre 81,4 % et 97,8 %) ont dit avoir reçu un appel téléphonique d'une infirmière hygiéniste, mais pas nécessairement dans un délai de 48 heures après leur sortie. L'offre d'une visite à domicile était uniformément élevée, mais nous avons constaté des écarts significatifs dans les taux d'acceptation (qui variaient entre 40,8 % et 76,2 %). Les principales variables prédictives de l'acceptation d'une visite à domicile étaient la naissance d'un premier enfant vivant, la faiblesse du soutien social, l'opinion maternelle relativement mauvaise des services reçus pendant le travail et l'accouchement, un état de santé maternel relativement mauvais selon l'intéressée, la probabilité de dépression du post-partum, l'opinion maternelle relativement mauvaise des services offerts par l'unité post-partum, et le taux d'allaitement maternel.

Conclusion : Le volet des visites à domicile de ce programme universel est mis à la portée de la plupart des femmes par le biais d'un suivi téléphonique. Cependant, les taux d'acceptation des visites varient beaucoup d'un endroit à l'autre. Cela donne à penser que les femmes qui éprouvent des problèmes ou qui ont des besoins particuliers sont celles qui acceptent qu'on leur rende visite. Il faudrait pousser la recherche pour orienter l'élaboration de programmes et de politiques fondés sur les résultats en ce qui concerne les visites à domicile post-partum effectuées par des infirmières.

The Canadian Institutes of Health Research - Institute of Population and Public Health (IPPH) and the Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information, are pleased to launch a new joint publication on knowledge translation (KT).

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