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INTERVENÇÕES NA ADAPTAÇÃO À PARENTALIDADE NO PERÍODO NEONATAL NOS CUIDADOS DE SAÚDE PRIMÁRIOS: SCOPING REVIEW

INTERVENTIONS SUPPORTING PARENTAL ADAPTATION IN THE NEONATAL PERIOD IN PRIMARY HEALTH CARE: SCOPING REVIEW

INTERVENCIONES PARA LA ADAPTACIÓN PARENTAL NEONATAL EN ATENCIÓN PRIMARIA DE SALUD: SCOPING REVIEW

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RESUMO

Introdução: A transição para a parentalidade constitui um período crítico de vulnerabilidade emocional e relacional, exigindo intervenções estruturadas nos cuidados de saúde primários. Neste contexto, a visita domiciliária tem emergido como uma estratégia central de apoio às famílias com recém-nascidos, permitindo intervenções mais próximas e contextualizadas.
Objetivo: Mapear a evidência sobre intervenções nos cuidados de saúde primários, com **particular** enfoque na visita domiciliária, descritas como facilitadoras da adaptação à parentalidade durante o período neonatal (0–28 dias), identificando os seus principais componentes e analisando a sua relevância para a prática especializada em Enfermagem de Saúde Familiar (EESF).
Métodos: Scoping review segundo metodologia JBI (2024), reportada com PRISMA-ScR. Pesquisa em PubMed, CINAHL Ultimate e Scopus (outubro–dezembro 2025), com literatura cinzenta. Seleção e extração por dois revisores independentes. Síntese descritiva e temática.
Resultados: Foram incluídos 16 documentos. Identificaram-se cinco componentes centrais: avaliação familiar estruturada, educação parental individualizada, promoção do vínculo pais-bebé, suporte emocional e coparentalidade, e continuidade relacional com articulação comunitária. Os estudos apresentaram desenhos, populações e medidas de resultado heterogéneos.
Conclusão: A visita domiciliária constitui uma estratégia relevante nos cuidados de saúde primários para apoiar a adaptação parental no período neonatal, integrando componentes que evidenciam a sua natureza multidimensional e centrada na família. Estes achados podem contribuir para orientar a prática especializada em Enfermagem de Saúde Familiar e reforçam a necessidade de intervenções estruturadas e baseadas na evidência.

Palavras-chave: cuidados de saúde primários; enfermagem de saúde familiar; parentalidade; recém-nascido; visita domiciliária

ABSTRACT

Introduction: The transition to parenthood is a critical period of emotional and relational vulnerability, requiring structured interventions in primary health care. In this context, home visiting has emerged as a central strategy to support families with newborns, enabling more contextualised and proximity-based care.
Objective: To map the evidence on primary health care interventions, with a particular focus on home visiting, described as supporting parental adaptation during the neonatal period, identifying their key components and discussing their relevance for Family Health Specialist Nursing practice.
Methods: A scoping review was conducted following Joanna Briggs Institute (JBI, 2024) methodology and reported in accordance with PRISMA-ScR. The search was conducted in PubMed, CINAHL Ultimate, and Scopus (October–December 2025), including grey literature. Study selection and data extraction were conducted independently by two reviewers. Data were analysed using descriptive and thematic synthesis.
Results: Sixteen documents were included. Five core components were identified: structured family assessment, individualised parental education, promotion of parent–infant bonding, emotional support and co-parenting, and relational continuity with community linkage. Included studies were heterogeneous in design, population, and outcomes assessed.
Conclusion: Home visiting constitutes a relevant primary health care strategy to support parental adaptation in the neonatal period, integrating components that reflect the multidimensional and family-centred nature of this approach. These findings may inform Family Health Specialist Nursing practice and reinforce the need for structured, evidence-based interventions.

Keywords: family nursing; house calls; infant; newborn; parenting; primary health care

RESUMEN

Introducción: La transición a la parentalidad es un período crítico de vulnerabilidad emocional y relacional que requiere intervenciones estructuradas en atención primaria de salud. En este contexto, la visita domiciliaria ha emergido como estrategia central de apoyo a las familias con recién nacidos, permitiendo intervenciones próximas y contextualizadas.
Objetivo: Mapear la evidencia sobre intervenciones en atención primaria de salud, con énfasis en la visita domiciliaria, descritas como facilitadoras de la adaptación a la parentalidad durante el período neonatal, identificando sus componentes y su relevancia para la práctica de Enfermería Especializada en Salud Familiar.
Métodos Scoping review según metodología JBI (2024), reportada con PRISMA-ScR. Búsqueda en PubMed, CINAHL Ultimate y Scopus (octubre–diciembre 2025), con literatura gris. Selección y extracción por dos revisores independientes. Síntesis descriptiva y temática.
Resultados: Se incluyeron 16 documentos. Se identificaron cinco componentes centrales: evaluación familiar estructurada, educación parental individualizada, promoción del vínculo padres-bebé, apoyo emocional y coparentalidad, y continuidad relacional con articulación comunitaria. Los estudios presentaron heterogeneidad en el diseño, la población y los resultados evaluados.
Conclusión: La visita domiciliaria constituye una estrategia relevante en atención primaria de salud para apoyar la adaptación parental en el período neonatal, integrando componentes que reflejan su naturaleza multidimensional y centrada en la familia. Estos hallazgos pueden contribuir a orientar la práctica de Enfermería Especializada en Salud Familiar y refuerzan la necesidad de intervenciones estructuradas y basadas en la evidencia.

Palabras clave: atención primaria de salud; enfermería familiar; parentalidad; recién nacido; visita domiciliaria

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INTRODUCTION

The transition to parenthood is a normative milestone in the family life cycle, involving profound emotional, relational, and functional changes. Although expected, the early postnatal period can be particularly vulnerable when individual, relational, or contextual factors heighten parental stress, challenging family stability and requiring caregivers to progressively adapt to their new role — reorganising family routines, roles, and bonds (Wright & Leahey, 2023; Meleis, 2012).

Within nursing science, Meleis' Transitions Theory (2012) offers a relevant framework for understanding parental adaptation: it conceptualises transitions as processes of change unfolding over time, requiring professionals to assess indicators of healthy transition and facilitate the development of new roles, competencies, and identities. Applied to the postnatal period, this framework highlights the need for structured assessment and timely intervention to support the family unit.

The initial period following birth is particularly challenging, with postpartum depressive symptoms affecting a substantial proportion of mothers and potentially compromising family adaptation and infant development (Wojcieszek et al., 2023; Wang et al., 2021). In Portugal, postpartum depression affects 10–15% of mothers, and about 50% experience postnatal blues in the first weeks of life (DGS, 2020; SNS24, 2024), reinforcing the need for early and structured family support.

Primary health care (PHC) plays a central role in responding to these needs, as the key entry point for postnatal family follow-up. The Family Health Specialist Nurse (FHSN), through specific training and a systemic perspective, is well positioned to support adaptation to parenthood by integrating emotional, relational, educational, and contextual dimensions of care, including strengthening parental competencies, promoting parent–infant bonding, and identifying vulnerabilities. Among PHC strategies, home visiting stands out for delivering care within the family's real-life context, fostering a relationship-centred, proximity-based approach (Wojcieszek et al., 2023).

Home visiting is recognised nationally and internationally as a key postnatal PHC strategy, promoting continuity of care, partnership with families, and parental empowerment (DGS, 2013, 2020; Cardoso et al., 2024). However, despite its recognised relevance, disparities in implementation across family health units persist. Moreover, although several reviews address early parenting support, evidence specifically focusing on the neonatal period within PHC remains fragmented, with limited clarity regarding core intervention components and their applicability to family health nursing practice. Mapping the available evidence is therefore essential to inform FHSN practice, optimise postnatal care, and identify priorities for future research.

To map the evidence on PHC interventions, with a particular focus on home visiting, described as supporting parental adaptation during the neonatal period, and to identify their key components and discussing their relevance for FHSN practice.

Review Question (PCC Framework)

What interventions have been described in primary health care as supporting parental adaptation during the neonatal period?

1. METHODS

This scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews as outlined in Chapter 10 of the JBI Manual for Evidence Synthesis (Peters et al., 2024) and reported in accordance with the PRISMA Extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The review protocol was prospectively registered on the Open Science Framework (OSF) (https://doi.org/10.17605/OSF.IO/S382J).

1.1 Eligibility Criteria

Inclusion criteria were defined according to the PCC (Population, Concept, Context) framework (Table 1).

Table 1 – PCC Framework

Element	Description
Population (P)	Families transitioning to parenthood with newborns (0–28 days), including mothers, fathers, primary caregivers, and the family as a un Studies including premature babies and older infants were considered when interventions specifically targeted the neonatal period.
Concept (C)	Interventions supporting adaptation to parenthood in the neonatal period: including educational, relational, emotional, functional, preventive, or supportive, with potential relevance to FHSN practice.
Context (C)	Primary health care (PHC) settings (family health units, community health centres) and equivalent community-based contexts, including home visiting as a key intervention modality.

Studies exclusively conducted in hospital or tertiary care settings without a PHC transition component, prenatal interventions without neonatal linkage, interventions focused solely on the newborn's clinical condition without parental adaptation support, study protocols without published results, and documents without full-text access were excluded. Studies involving professionals other than family health nurses were included when their intervention components were relevant to parental adaptation and potentially transferable to FHSN practice in PHC or equivalent community-based settings. This approach was consistent with the review objective of mapping intervention components rather than restricting evidence to a single professional group.

1.2 Types of Evidence Sources

Eligible evidence sources included primary studies of any methodological design, relevant evidence syntheses, and grey literature describing or synthesising interventions supporting parental adaptation during the neonatal period in primary health care or equivalent community-based settings, with potential relevance to Family Health Specialist Nursing practice.

1.3 Search Strategy

The search strategy followed three sequential stages. First, a limited search was conducted in PubMed and CINAHL Ultimate to identify relevant keywords and controlled vocabulary (MeSH and CINAHL Headings) based on the PCC framework. Second, database-specific

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search strategies were applied in PubMed (MEDLINE), CINAHL Ultimate (EBSCOhost), and Scopus (Elsevier) between October and December 2025. Third, grey literature was searched in RCAAP and on the Portuguese Nursing Council website.

Searches were limited to publications from 2020 to 2025 and to English or Portuguese. Full-text availability was required for inclusion. The 2020–2025 timeframe was selected to capture contemporary PHC interventions reflecting current models of care and family health practices. The complete search strategies for each database are provided in Appendix 1.

A combination of controlled vocabulary (MeSH, CINAHL Headings) and free-text terms was used, including terms addressing the postnatal/newborn period, parenting and parental adaptation, family nursing, primary health care, and home visiting. Search strategies were adapted to the indexing system of each database.

1.4 Study Selection

All identified records were exported to Rayyan® for duplicate removal and screening, conducted in two stages by two independent reviewers: title/abstract screening followed by full-text assessment. Disagreements were resolved through discussion and consensus, and exclusion reasons at full-text stage were documented in the PRISMA-ScR flow diagram. In line with JBI recommendations, no formal critical appraisal of methodological quality was undertaken, as the review aimed to map the extent and nature of available evidence.

1.5 Data Extraction and Analysis

Data were extracted using a pre-developed instrument aligned with JBI guidance, including study identification, methodological characteristics, PCC elements, detailed description of interventions (components, professionals involved, duration, frequency, and tools), main outcomes related to parental adaptation, implications for FHSN practice, and reported study limitations. Data extraction was performed independently by two reviewers, with discrepancies resolved by consensus. Findings were synthesised using descriptive and thematic analysis. Thematic analysis followed an inductive approach, allowing the identification of recurring intervention components across studies. Codes were iteratively refined and grouped into higher-order categories, which informed the analytical synthesis. The analytical process was conducted iteratively to ensure consistency and credibility of the findings.

2. RESULTS

The search identified 758 records. After removing 97 duplicates, 661 references were screened by title and abstract, of which 70 were selected for full-text assessment. Of these, 58 were retrieved and 12 could not be accessed. Following full-text evaluation, 43 records were excluded, mainly due to populations outside the neonatal period, lack of focus on parental adaptation, or ineligible study design. One additional document was identified through grey literature. Sixteen documents were included: 13 primary studies, two scoping reviews, and one grey literature source (Figure 1).

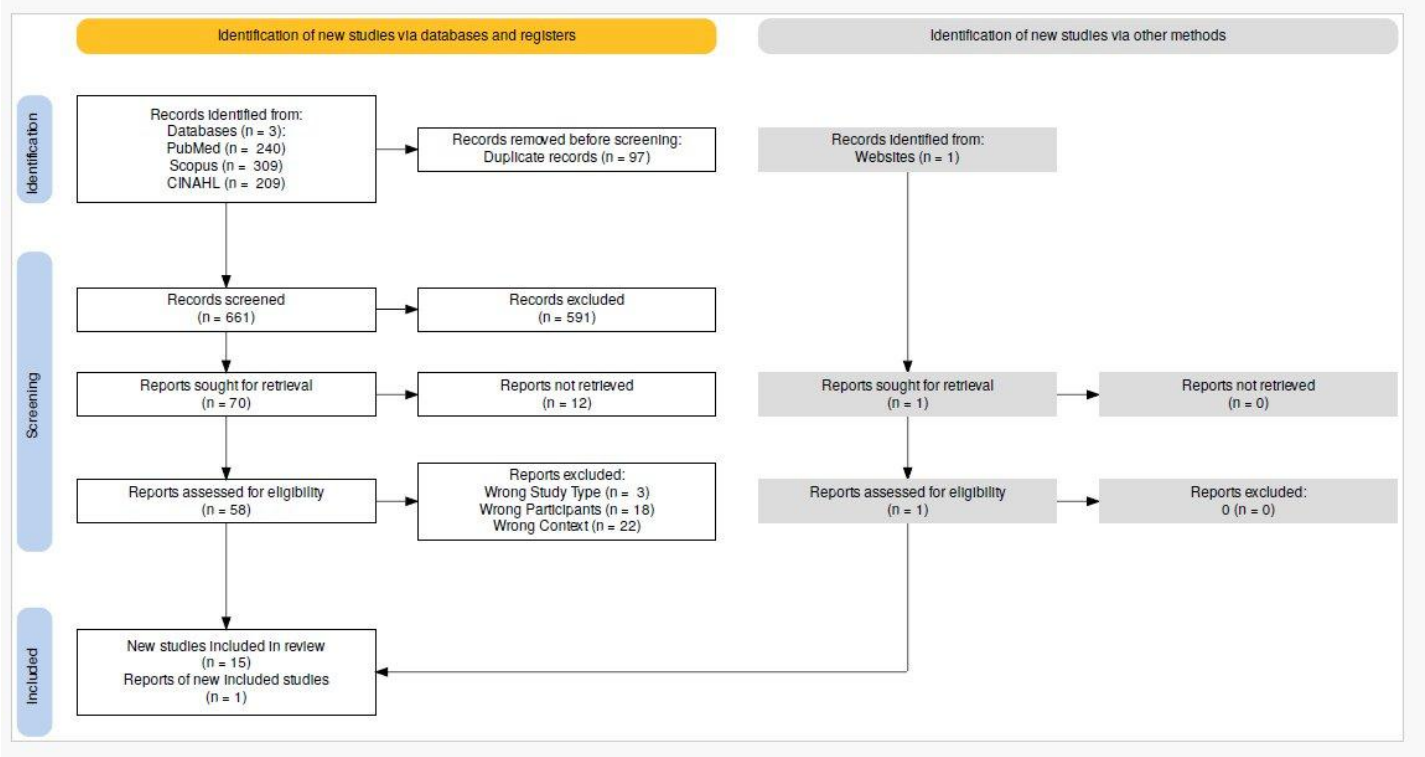


Figure 1 – PRISMA-ScR flowchart of study selection. Source: Adapted from PRISMA-ScR.

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The included studies were conducted across nine countries and used diverse methodological designs. The 13 primary studies were predominantly quantitative (n=8), including seven reports based on randomised controlled trials. Qualitative (n=3), feasibility, and case study designs were also included (Table 2).

Table 2 – Characteristics of included documents

ID	Authors (year)	Country	Study type	Population / Setting	Intervention / Professionals	Sample / intervention intensity	Main outcomes
S1	Baziyants et al. (2025)	USA	RCT 5-year follow-up	Families with newborns; home	Family Connects; universal postnatal HV; nurses	n=401 (201 intervention; 200 control); 1–3 HV; 5-year follow-up	↓ depressive symptoms; ↑ social well-being at 5 years
S2	Baziyants et al. (2023)	USA	RCT	Families with newborns; home	Family Connects; universal postnatal HV; nurses	n=496 (255 intervention; 241 control); 1–3 HV; outcomes at 2 years	↑ positive parenting
S3	Mersky et al. (2022)	USA	Quasi-experimental	Families with newborns; home	Family Connects; universal postnatal HV; nurses	n=489; up to 4 HV; outcomes at 6 months	No significant effects at 6 months
S4	Ammerman et al. (2022)	USA	RCT	Mother–father dyads; home	Family Foundations Home Visiting (FFHV); co-parenting; trained facilitators	n=150 families/dyads (70 FFHV; 80 HV); 11 sessions; CACE adherence ≥9 sessions	↓ depression/PTSD; ↓ paternal aggression; ↑ parent–infant interaction
S5	Cato et al. (2024)	Sweden	Pilot RCT	Parents of newborns; home	Educational home visit; nurse	n=88 parents (46 intervention; 42 control); 1 HV; follow-up at 3 months	↑ parental self-efficacy (infant sleep)
S6	Baraldi et al. (2025)	Sweden	RCT	Families with extremely preterm infants; home	SPIBI; trained interventionist	n=130 infants (66 intervention; 64 control); 10 HV; assessment at 12 months	No overall effect; subgroup benefit
S7	Schuetz Haemmerli et al. (2022)	Switzerland	Qualitative	Parents of preterm infants; hospital/home	Transition to Home; APN-led interprofessional care	n=39 parents; up to 9 HV + 3 follow-up calls; support to 6 months post-discharge	Perceived well-being, autonomy, confidence, and continuity
S8	Flierman et al. (2024)	Netherlands	Feasibility study	Families with moderate preterm infants; home	TOP; paediatric physiotherapists	n=32 families; 6 HV; up to 6 months corrected age	↑ self-efficacy and parental sensitivity; satisfaction 9.4/10
S9	Youn et al. (2021)	South Korea	Multicentre RCT	Families with very preterm infants; home/community	Preventive programme; specialised NICU nurses + paediatric physiotherapists	n=138 infants (69 intervention; 69 control); 4 HV+ up to 12 group sessions; up to 6 months corrected age	No significant differences in primary or parental outcomes
S10	Alarcão et al. (2021)	Brazil	RCT	Adolescent mothers; home	Primeiros Laços; longitudinal HV programme	n=80 mothers (40 intervention; 40 care-as-usual); intervention from first trimester of pregnancy to child age 24 months	↑ mother–infant attachment
S11	Sæther et al. (2024)	Norway	Qualitative	First-time parents; PHC/home	New Families; public health nurses	n=13 parents from 7 families; from gestational week 28 to child age 2 years; number of visits tailored to family needs	Parental confidence; relational/informational continuity
S12	Al-Adhami et al. (2025)	Sweden	Qualitative	First-time parents in vulnerable areas; home	Together for a Safe Start; nurse + parental counsellor (social services)	n=17 parents (12 mothers; 5 fathers); prenatal contact + 6 HV through 15 months + closing visit at 24 months	Perceived trust and practical, socioemotional and relational support
S13	Yllera et al. (2025)	Portugal	Scoping review	Families with newborns; home	Family nursing interventions	Not applicable — evidence synthesis; intensity varied	Intervention components and gaps identified
S14	Ribeiro et al. (2021)	Portugal	Case study	Family with newborn; PHC	MDAIF-guided intervention; family nurse	n=1 family; intervention intensity not clearly reported	Gains in family adaptation and functioning
S15	Cardoso et al. (2024)	Portugal	Professional guideline / grey literature	Families transitioning to parenthood	Good Practice Guide; specialist maternal and obstetric health nursing	Not applicable — professional guideline; no fixed intervention dose	Systematisation of recommended practices
S16	Tazza et al. (2023)	Italy	Scoping review	Expectant/new parents; home	Brazelton-based HV programmes; varied professionals	19 records included; frequency/intensity heterogeneous across programmes	↑ parental knowledge; heterogeneous effects on other outcomes

Note. APN: Advanced Practice Nurse; CACE: Complier Average Causal Effect; FFHV: Family Foundations Home Visiting; HV: home visit; MDAIF: Dynamic Model of Family Assessment and Intervention; NICU: Neonatal Intensive Care Unit; PHC: primary health care; RCT: randomised controlled trial; SPIBI: Stockholm Preterm Interaction-Based Intervention; TOP: Transmural Developmental Support Programme. For evidence syntheses and grey literature, sample size and intervention intensity are reported as not applicable when no single intervention sample or fixed intervention dose could be attributed. When intervention intensity was not explicitly reported in the source, this is indicated accordingly.

Across studies, five interrelated components described as supporting adaptation to parenthood were identified: (i) structured family assessment and clinical needs screening; (ii) individualised parental education and practice-based skill development; (iii) promotion of parent–infant bonding through guided interaction; (iv) non-judgemental emotional support including co-parenting facilitation; and (v) relational continuity, care coordination, and community resource linkage (Table 3).

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Table 3 – Synthesis of core intervention components identified across included evidence sources

Core intervention component	Key elements identified across studies	Supporting sources	n sources
Structured family assessment and clinical needs screening	Family assessment; psychosocial screening; identification of family needs, strengths and vulnerabilities	S1, S2, S3, S7, S13, S14, S15	7
Individualised parental education and practice-based skill development	Practical newborn care; breastfeeding; infant sleep; responsive caregiving; parental coaching	S1, S2, S3, S5, S6, S7, S8, S9, S10, S12, S14, S15, S16	13
Promotion of parent–infant bonding through guided interaction	Guided observation, modelling, parent–infant interaction, sensitivity, attachment support	S6, S7, S8, S9, S10, S12, S15, S16	8
Non-judgemental emotional support including co-parenting facilitation	Validation, reassurance, confidence building, emotional support, co-parenting facilitation	S4, S7, S9, S11, S12, S15	6
Relational continuity, care coordination and community resource linkage	Follow-up, continuity of care, multidisciplinary coordination, referral to health, social and community resources	S1, S2, S3, S7, S10, S11, S12	7

Note. Study IDs correspond to Table 2. The number of supporting sources indicates how frequently each component was identified across the included evidence sources and should not be interpreted as a measure of intervention effectiveness or strength of evidence. Individual evidence sources could contribute to more than one intervention component.

3. DISCUSSION

This review highlights home visiting as a key PHC strategy supporting adaptation to parenthood in the neonatal period, though its impact may depend less on the model itself than on how components are combined, tailored, and delivered according to family needs.

A key distinction emerges between universal, low-intensity interventions and targeted, higher-intensity programmes: universal models facilitate early identification of needs at population level, while targeted approaches provide more sustained, relationally focused support for vulnerable families. Rather than competing, universal and targeted models appear complementary, with universal home visiting supporting early identification and targeted programmes providing greater intensity for vulnerable families.

National and international guidelines recognise home visiting as a key postnatal intervention, emphasising continuity of care, partnership with families, and parental empowerment (DGS, 2013, 2020; Cardoso et al., 2024). Unlike previous reviews, which focused on broader family nursing interventions (Yllera et al., 2025) or specific programmes (Tazza et al., 2023), this review synthesised intervention components supporting parental adaptation during the neonatal period, providing a transferable framework for Family Health Specialist Nursing practice in primary health care.

Structured family assessment plays a key role in guiding intervention planning through comprehensive assessment of family needs. However, the lack of standardised protocols limits consistency across settings. Individualised parental education was the most frequently identified component, while parent–infant interaction and bonding, relational continuity, and structured family assessment were also recurrent across intervention models (Table 3).

Individualised parental education, including demonstration and practice-based guidance, was described across several studies, with some reporting improvements in parental self-efficacy. These interventions included practical support in newborn care, sleep, and cue-based strategies, tailored to the family context.

However, self-efficacy should be interpreted as a distinct outcome from intervention acceptability, feasibility, parental satisfaction, mental health, or parent–infant bonding. Although these outcomes are interrelated, they reflect different dimensions of adaptation and were assessed using different measures across studies, limiting direct comparison.

Interventions targeting the parent–infant relationship focused on guided observation, modelling, and relational feedback, and supported the recognition of infant cues, enhanced sensitivity, and improved interaction quality. Among families with preterm infants, findings were less consistent across intervention models, with some studies reporting no significant overall effects or benefits restricted to specific subgroups, while others reported improvements in parental self-efficacy, confidence, or satisfaction. In contrast, the study involving adolescent mothers reported a positive effect on mother–infant bonding, although evidence in this population was limited to a single study. Therefore, findings in adolescent parents are better characterised as limited in scope rather than inconsistent.

Emotional support emerged as a central relational component, characterised by validation, normalisation of parental experiences, and professional availability. Co-parenting facilitation was less frequently addressed but, when included, was described in studies reporting improvements in parental mental health and relational functioning. These findings align with Meleis' Transitions Theory, which emphasises competence development as a key indicator of successful adaptation. Despite its relevance, co-parenting remains underrepresented in current intervention models, indicating an important gap.

Relational continuity and community linkage appear to function as enabling conditions that support the implementation of other components. Continuity of care is described as supporting trust and engagement, while community linkage contributes to sustained support over time**.** Rather than acting as isolated intervention components, these elements appear to support the

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delivery of educational and relational strategies by promoting sustained therapeutic relationships and facilitating timely access to additional health and social resources.

The diversity of methodological designs, ranging from randomised controlled trials to qualitative and case study designs, limits direct comparability and precludes conclusions regarding intervention effectiveness, consistent with the purpose of a scoping review. The heterogeneity of findings reflects the complexity of parental adaptation and suggests that interventions rely on the integration of multiple strategies adapted to context, timing, and family characteristics. Although randomised controlled trials used designs better suited to estimating intervention effects, the absence of critical appraisal in this scoping review precludes conclusions regarding the relative strength or certainty of the evidence. Nevertheless, these studies provided more direct evidence on intervention-related outcomes, while qualitative and feasibility studies contributed to an understanding of acceptability, feasibility, satisfaction, and families' experiences of care. These complementary perspectives are particularly valuable when analysing complex family-centred interventions that cannot be adequately understood through effectiveness outcomes alone.

Among the intervention models identified, Family Connects was the most frequently evaluated intervention model among the included primary studies. However, findings were not uniformly positive across outcomes and follow-up periods, with improvements in positive parenting and longer-term parental well-being contrasting with the absence of significant effects at six months in one quasi-experimental study. This variability suggests that intervention effects may depend on the outcomes assessed and timing of evaluation rather than supporting a uniform effect across domains.

These findings are broadly aligned with international and national guidelines, suggesting their potential relevance to the Portuguese context. Nurses were identified as key professionals in delivering these interventions, with competencies aligned with Family Health Specialist Nursing practice. In Portugal, the quality standards for specialist nursing in family health (Ordem dos Enfermeiros, 2015) explicitly frame the FHSN role around family assessment, health promotion, and parental support. Within the transition to parenthood, these competencies translate into the identification of family needs, resources, and vulnerabilities; individualised planning of care; promotion of parental competence, parent–infant interaction, and co-parenting; relational continuity; coordination and referral to health and community resources; and evaluation of family outcomes. These competencies closely map onto the five intervention components identified in this review, reinforcing the alignment between the evidence and the normative foundations of family health nursing practice. From an organisational perspective, these findings suggest that several components could be operationalised within Portuguese Family Health Units through structured postnatal home visiting pathways led by Family Health Specialist Nurses. Their implementation would require protected time for home visits, training in family assessment and relational interventions, and effective coordination with maternity hospitals, community resources, and multidisciplinary primary care teams.

Taken together, the recurrence of core intervention components across different models suggests that the potential impact of postnatal home visiting may depend less on the adoption of a specific programme than on how these components are combined, delivered with sufficient intensity, and tailored to family needs.

Limitations

This review presents several limitations. Heterogeneity in the conceptualisation of parental adaptation and in intervention operationalisation — including differences in components, intensity, and populations — limits direct comparability. The inclusion of diverse methodological designs, consistent with scoping review methodology, precludes conclusions on intervention effectiveness, and the absence of critical appraisal, per JBI guidance, restricts assessment of evidence strength.

The search was restricted to studies published in English and Portuguese between 2020 and 2025, which may have excluded relevant evidence published in other languages or outside this timeframe. National studies were also limited, constraining applicability to the Portuguese context.

Finally, the identification of intervention components relied on interpretative synthesis, which may introduce subjectivity. The lack of standardised definitions for concepts such as "home visiting" and "neonatal period" further limits comparability and transferability of findings.

Restricting inclusion to studies available in full text may have resulted in the exclusion of potentially relevant evidence that was not accessible through the selected databases.

CONCLUSION

This scoping review mapped the available evidence on primary health care (PHC) interventions, particularly home visiting, described as supporting adaptation to parenthood in families with newborns.

Across these models, the findings suggest that the potential contribution of home visiting to parental adaptation may depend on how intervention intensity, relational quality, continuity of care, and family-specific needs are addressed. These findings also highlight the potential contribution of the Family Health Specialist Nurse (FHSN) to the delivery of tailored, systemic, and family-centred interventions during the transition to parenthood. Important gaps remain, including the limited availability of national

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evidence, the scarcity of studies focusing specifically on the early neonatal period in PHC, and the absence of standardised home visiting protocols (Yllera et al., 2025). Future research should prioritise the development, feasibility testing, and evaluation of structured home visiting protocols during the neonatal period in Portuguese primary health care, including their acceptability, implementation requirements, and potential contribution to parental and family outcomes.

AUTHORS' CONTRIBUTION

Conceptualization, F.M. and E.L.; data curation, F.M. and M.D.S.; formal analysis, F.M. and M.D.S.; investigation, F.M. and M.D.S.; methodology, F.M., M.D.S. and E.L.; project administration, F.M.; resources, F.M.; supervision, E.L.; validation, M.D.S.; visualization, F.M., M.D.S. and E.L.; writing – original draft, F.M.; writing – review & editing, F.M., M.D.S. and E.L.

CONFLICT OF INTERESTS

The authors declare no conflict of interests.

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