

# Evaluation of home visits in the area of action of a health center of the state of Guerrero, Mexico

## Abstract

**Purpose:** The home visit is the activity that arises from a part of the female population is committed to helping people to improve their health status, went to the home to provide the necessary care. The home visit is linked to various monitoring and control programs. That is why we seek to know what has been the impact of the home visit on patients of the Health Center of Chilpancingo of Los Bravo, Guerrero.

**Material and Methods:** quantitative, cross-sectional study, in users older than 18 years old, preferably housewives and nurses of the different shifts. An instrument with sociodemographic data was used to measure the frequency of the home visit with internal validation of .903 on the Cronbach scale, and the instrument for the nurse (sociodemographic data and risk factors). 231 surveys were applied, 227 were applied to users.

**Results:** 93.4% of users report that they have never scheduled home visits; the nursing staff mentions that if they do (25% have almost always been found in their home and 75% rarely), the main obstacle is that 50% of the streets are paved (75%), the distance is more than 5 kilometers (25%), there is no type of security (75%), being their work area high risk, not by the work they do but the risks they are exposed to (assaults, kidnappings, etc.).

**Conclusion:** The State of Guerrero is among the first places in violence and homicides; Chilpancingo has the first place at the national level as one of the cities with greater insecurity according to the news, which could be a limiting factor for conducting the home visit.

**Keywords:** community, home visit, nursing, first level, prevention, family home, health institutions, greater insecurity, psychosocials, vaccination, primary care, health system, human resource, social pediatric

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## Introduction

The community nurse is part of a group of health professionals who will take charge of improving the welfare of the population in general. The activities he carries out are of the utmost importance, since it is based on the health of the individuals. Reference is made to prioritize activities in the first level field of action, since it is the first contact the patient has with the nurse. In Brazil, a study was carried out or qualitative, on the impact of family home visits on the learning of medical students in the area of social pediatrics, in 2013. We studied a group of students of social pediatrics from the 2006-II semester until 2011-II, from the undergraduate program of medicine of the University of Antioquia, interviews, surveys, focus groups of students and professors were used. It was found that the visit allows them to go beyond the health institutions, broadens their biological perspective, made them more global, corroborating the information that can sometimes be checked or confronted with reality, sometimes even changing diagnoses, by the appearance of new elements such as psychosocials, lifestyles, the very reality of life and the daily life of families, gives them a greater objectivity.<sup>1</sup> In Costa Rica in 2015; research they conducted qualitative to, Analytic to observational. The analysis was made based on the grounded theory; The population assigned to the Pavas Health Area was selected during 2013, as well as the technical staff working in the sector. The results were divided into three sections: 1. Characterization home visit program, 2. The figure of ATAP, as this is the main human resource responsible for

conducting home visits of primary care health system costar rice and 3. The guidelines for the improvement of the domiciliary visit program, oriented in three areas: health system, Home Visit Program and figure of the ATAP. The home visit should be made between 8 and 10 home visits per day, to be considered effective must include at least three actions, including taking blood pressure, vaccination, taking anthropometric measures, delivery of deodorants and oral rehydration serum, delivery of references and health education.<sup>2</sup>

In the year of 2013 in Cuernavaca, Morelos cross-ys research was developed and incorporated the strategy of triangulation between methods, to propose a comprehensive care model for the detection, diagnosis and management of mistreated in health services. Rights and obligations conclu yó health staff know the rules and regulations for the care [...] and.<sup>3</sup> At the Autonomous University of Nuevo Leon in 2013 A descriptive, transversal and observational study was conducted Titu lad or “ E nfermería professional in the prevention and control of diabetes mellitus, in the first level of care.” A questionnaire was applied to 79 nursing professionals working in the first level health centers, which correspond to the four Jurisdictions of the Ministry of Health of the metropolitan area of Nuevo León. It was found that health professionals record the activities of home visits, (...) in the daily activity report, that is, that they comply with the program’s indication and a lower percentage do so in the program’s own records, this may favor a - better customer tracking.<sup>4</sup> In Guerrero, a quasi-experimental research was carried out in 1996, which was titled

“Permanent hiring strategies within the universal vaccination program”, in Tixtla, Guerrero, Mexico, from April to December 1994. Two AGEB were studied with an average of 100 children under one year in each. In the intervention area, people from the community were permanently hired for early recruitment (before two months of age) and timely vaccination of children with incomplete vaccination schemes (according to their age). In the control area, periodic campaigns continued. Notifying that home visits were carried out; it was sought to achieve a precise location of the domiciles (...) At the beginning of the vaccination through home visits it was observed that an important part of the population decides to wait for the visit, the intervention strategy raised the percentage of schemes complete vaccinations (according to age) from 21.1 to 93.5% in children under one year, as well as the early recruitment.<sup>5</sup>

The home visit is a fundamental intervention in the field of action of the community nurse; this activity is carried out in the population that is in charge of a Health Center. Through these, various benefits are obtained, since with it one can get to complement the programs that are carried out in the first level of attention. The community nurse is intended to provide care to patients, both at the health center and at home, these will help improve the patient's health, but also act to promote health-related activities directed towards the entire community that is in charge, they try to restore the health of the entire population. The community nurse works from the community as such, followed by the families and finally by the individual. Priority is given to the needs of each individual that puts their welfare state at risk. Since the prioritization has been done, a new categorization of the intervention is given, it is categorized in different programs such as the vaccination program, family planning program, among others, these have a common intervention that is the visit domiciliary. Currently this intervention has been in decline, since they are faced with various difficulties, mention can be made of demographic problems, economic, among others. This problem has been leaving several consequences, since the patients who are in control in that health unit are stopped monitoring their condition. There are several factors that have led to this intervention is not performed in the right way, in the context of the nurse could be mentioned about the lack of interest of the nurse towards the health of patients, on the other hand has the lack of training of health professionals who are working in that institution. The patient's difficulties relate to not give yourself to be visited at home, you provide a false address or do not remember exactly home, changed or domicile and fail to inform their health center corresponding.

Referring to the institution in which the nurse works, it can be mentioned that there is not enough human resources needed in the institution to perform the intervention, since in a health center various activities are carried out during the shift, which limits not to leave the health unit. Finally we can refer to society, which can be found that currently lives in a situation of low security that can limit the conduct of the home visit. A day not only training nurse, but also user training is needed, since this intervention allows to monitor and promote the health of the individual. The home visit should be carried out by the nurse responsible for the area accompanied by a male staff member who is working in a health center. According to Dorothea Orem in her “General Theory of Nursing” is composed of 3 theories related to each other: self-care theory, self-care deficit theory and theories of nursing systems. Defines health as “the state of the person characterized by the firmness or totality of the development of human structures and physical and mental function.”<sup>6</sup> Community

nursing is aimed at the global community and its actions are aimed at the population as a whole (...) to promote, protect, prevent, maintain and restore the health of the community.<sup>7</sup> Nursing care for individuals and families designed to: 1) promote and maintain health. 2) prevent diseases. This is provided during the transition from patients in the health care system to health-related services outside the hospital and / or health center facilities.<sup>8</sup> The community nurse provides direct care to patients and families and carries out political efforts to ensure resources to integrate populations, perform many functions, including those of epidemiologist, case manager for a group of patients, coordinator of the services provided to a group of individuals, school occupational health, visiting nurse or parish nurse.<sup>9</sup>

The Domiciliary Visit allows you to assess the environment and the reality of the users within your home. An integral and non-fragmented assessment allows us to deliver a care of the same characteristics, which is aimed at satisfying both physiological needs and higher needs.<sup>10</sup> The domiciliary visit is not a united, concrete and isolated activity, but it is the beginning, the continuity or the end of a process of attention at home. And it is divided into 5 parts: First, it is the preparation of the visit, in which you will consult your medical history before going to the home, you must agree on the day and time of the visit. Subsequently, the presentation at home, when the nurse goes to a home, does it on his own behalf and on behalf of the institution he represents, it is essential that he identify himself, what institution he belongs to and what is the reason for the visit, especially the first time you go to a home. The assessment can be completed in successive visits as the relationship between the nurse and the family is strengthened. Information must be obtained about the person requesting home care about the caregiver, the family group and the conditions of the home and surrounding environment. According to Virginia Henderson says that the dependent person will be valued the capacities and limitations for the satisfaction of their 14 basic needs. The planning of care allows establishing the objectives that must be achieved in the short, medium and long term. Establish agreements or pacts with the family and identify and mobilize available resources. There are two types of care in the home, direct professional care directed to the people who need them (sick, family group, care). And indirect professional care, are those that affect the improvement of the quality of life of people served at home, and are related to the use and mobilization of resources outside the family group. The evaluation of the visit allows measuring the results achieved since the previous visit. The improvements can be slow and evident, it is necessary that the nurse values the great effort and dedication that have been invested to achieve these small processes; here the importance of planning objectives in the short, medium and long term. The registration of the visit is the last stage in which once the visit is made it will be registered, it is important that there is a clinical documentation in the home, for use by the team and family, where they will include the data that can be interest in both as is the symptomatology, observed changes, care and medication prescribed and administered, date of the next visit of the nurse, among others.<sup>11</sup>

The benefits of the home visit are to improve health care, increase the participation and responsibility of the family in the care process, improve the quality of life of the users, grant a sense of intimacy and well-being, as people feel that this type of personalized assistance is more human, improves the delivery of education. It prevents the lack of social insertion, a benefit that can only be achieved in primary care, not at a secondary or tertiary level.<sup>12</sup> According to WHO (1981), there are some minimum criteria about situations that require priority

home care, in order to provide information, education and support to the individual (healthy or sick) and their family. Among these criteria are: Families with adults over 80 years of age, people living alone or without families, people who can not go to the health center, friends with seriously ill or disabled patients, people with recent hospital discharge and people with vital medication. Similarly WHO establishes some key goals based on these criteria, all home care program must meet, among them are: 1 a proportion of care to people who can not travel to the health center, 1 a proportion of the information, education and support to the sick person and his family, to facilitate the primary, secondary and tertiary prevention, to avoid unnecessary income, and to nificate the quality of attention of all the professionals involved: action protocols, clinical sessions, pain control, prevention of ulcers, among others and promoting the coordination between the offer of health and social services.<sup>13</sup> The visits must be previously planned with the consent, consent or request of those responsible for the address or head of the family. As a general rule, visits are highly appreciated and the villagers welcome the members of the team. It is important to remember that nobody is obligated to open their home to anyone. Therefore, we must work in a positive way demonstrating and verifying the benefits of this activity. In case there is rejection of the visit, the fact must be taken with naturalness and respect. As you can see the limits between everyday life and the professional side are very close in this relationship. For this reason it is always useful to be attentive and not to go beyond certain limits. These will always be given by the respect for autonomy, freedom and self-determination of individuals and families. It must be considered that each person and each family have their own life dynamics.<sup>14</sup>

### Materials and methods

The research was carried out in a Health Center of Chilpancingo de Los Bravo, Guerrero, was a quantitative study, of transversal design. The study population was to users older than 18 years, preferably housewives and nurses assigned to the Health Center of the different shifts. During the month of March 2017. The instrument used for the user consisted of 7 items on sociodemographic data and data that measure the frequency of the home visit with 12 items with internal validation of .903 on the Cronbach scale, and the instrument used for the nurse consisted of 8 items on sociodemographic data and 19 items of risk factors. The procedure began with the request of the field to Municipal Health to conduct the interview which was received favorable response to the request, proceeded to the survey of which 231 surveys were applied, 227 were applied to users of the Center of health; the sampling was carried out using the formula Epiinfo, under the following criteria 3000 dwellings, where the research report is considered that is made 20% of visits with a 95% confidence and a 5% error, 227 homes were selected as result of the sample, applying cluster sampling with replacement and systematic selection (1 out of every 13 houses), with respect to the nursing staff, 100% (4 nurses) was considered. An anonymous interview was used to respect confidentiality; which included socio-demographic, work and educational characteristics, which behaved as risk factors: Age, Sex, Marital Status, School Grade, Presence of children and illness. The project considered as basis for its application what is established by the general health law 2016, informing and requesting the researched their participation prior informed consent. The instrument of the nursing staff was delivered to them individually. It was explained that the questionnaires were anonymous and confidential, possible doubts were solved regarding their content and the respective explanation of the instrument was made. The instrument addressed to the user was applied directly explaining that the information provided was

anonymous and confidential and that for no reason would be used for other purposes. The project considered as a basis for its application what is established by the general health law 2016 in the field of research, the questionnaire was applied after informed consent, the confidentiality of the information was specified.

### Statistical Analysis

For the analysis of the data obtained, they were captured and processed in the statistical package SPSS in version 24, a descriptive statistic, univariate, bivariate analysis, were processed and graphed.

### Results

The sex that predominated in the study population was the female (79.7%) and the average age of 39.74. With regard to the attendance of the population, 42.2% attend the morning shift and only 0.4% of women attend the consultation during the day. In relation to the use of the health center, 73.6% is affiliated with Seguro Popular, 18.5% is entitled to IMSS and ISSSTE, while 7.9% does not go to any institution. In the survey applied to the user, 77.50% said they did not receive any explanation about the home visit, and only 14.10% mentioned that they received it. 61.7% of users does not identify the personnel responsible enfermer i to, while 6.20% do not remember. 61.7% do not know who is the nurse is in charge of your health. U n 6.6% does not remember who his nurse. However, there is a 32.2% who knows who their nurse is. 36.1% of l Study population goes for other reasons (see, emergencies) to the Health Center. While 36% go for some program of the PABS, 93.4% of the surveyed population that ca nun you have scheduled a home visit See Figure 1 & Figure 2. Programa del PABS que utilize el usuario with regard to scheduled appointments, 3.08% of female users always forget their appointments, while 3.08 % of men forget them regularly See Figure 3.

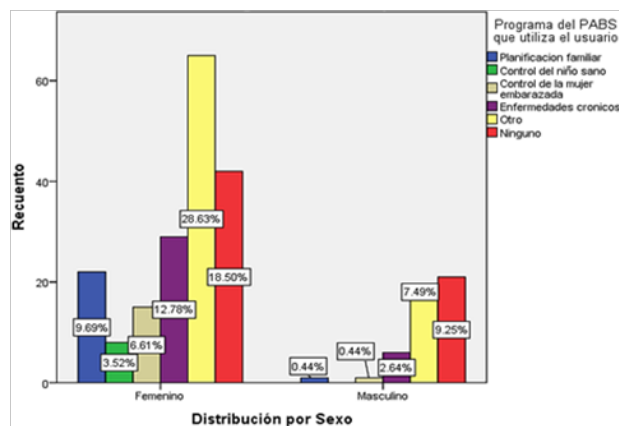
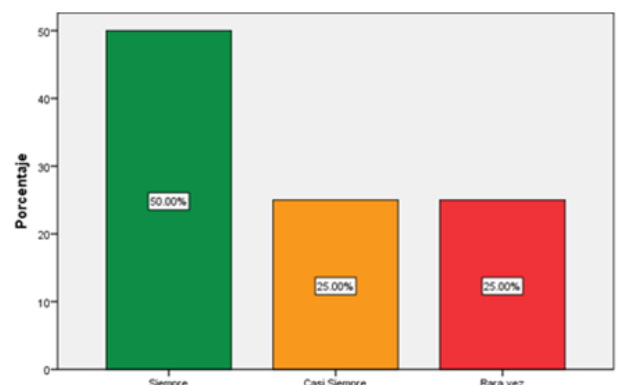


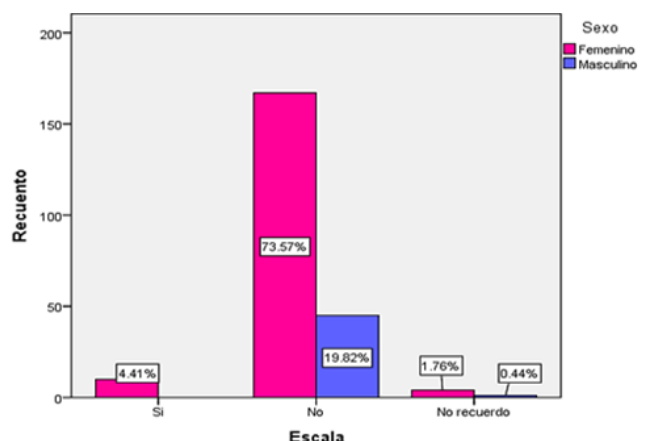
Figure 1 Program of the PABS that the user uses. Sources: Survey applied users and health personnel of a unit of first level of Chilpancingo: Guerrero, Mexico: April 2017

Regarding the nursing staff, 100% of them consider that their knowledge of the home visit is good (25% male and 75% female). However, 50% mentions that they want to receive training to improve the sites. While 25% of the Female sex or says that it is better to take an intensive course. The results show that 75% of the nursing staff has not received training, 75% of the female nurses perform their home visiting role while 25% of the male sex does so. To the nursing staff to survey him on whether he gives time to perform all their activities to do home visit 50% responded that rarely gives time and 25% said he never gives time. 25% of nurses said they rarely spend hours working

for conducting home visits and 75% said they almost always. 25% say the patients almost they always and rarely accept a home visit, respectively See Figure 4. Reference to accompanying you have to make home visits, 50% said they rarely accompany while 25% said they almost always. 50% of the nursing staff responded that when they made the home visit, they rarely found the correct address; while 25% answered that they always found it See Figure 5. To the patients that have been made the home visit 75% rarely it has been found at your home. 75% of nurses say that during the home visit there is never any security, while 25% say it rarely exists. 50% of nurses mention that the distance between the Health Center to the colonies is less than 1 kilometer away, while 25% say they are at a distance of 3 kilometers and 25% mention that they are more than 5 kilometers See Figure 6. 75% of the nurses say that 50% of the streets are paved, while 25% say that 25% are paved.

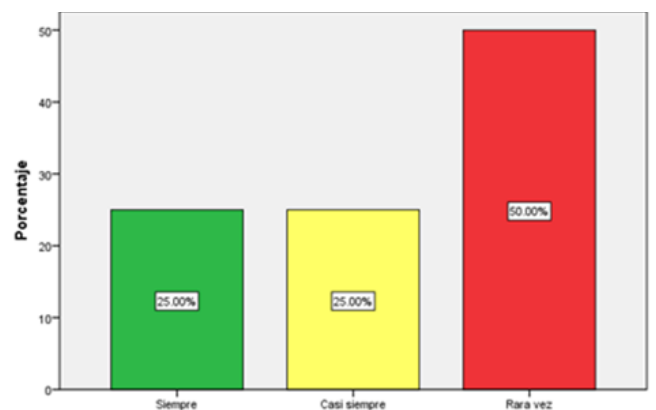


**Figure 4** Distribution of patients who accept home visits. Sources: Survey applied to users and health personnel of a first level unit in Chilpancingo, Guerrero, Mexico; April 2017.



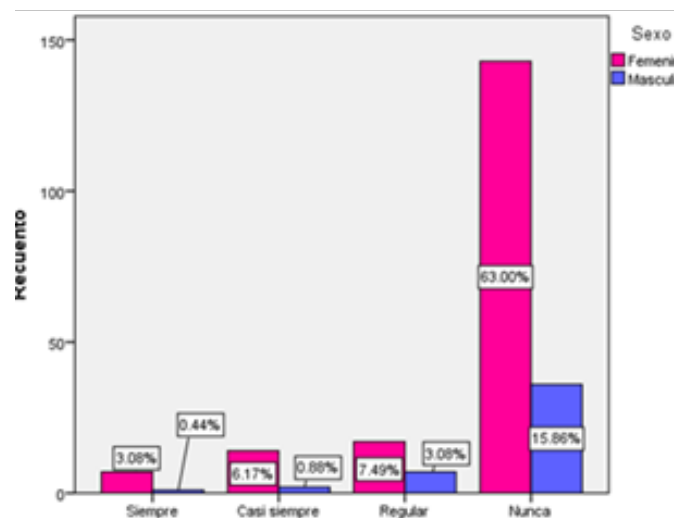
**Figure 2** During your visit to the health center you have scheduled some visits to your home.

Sources: Survey applied to users and health personnel of a first level unit in Chilpancingo, Guerrero, Mexico; April 2017.



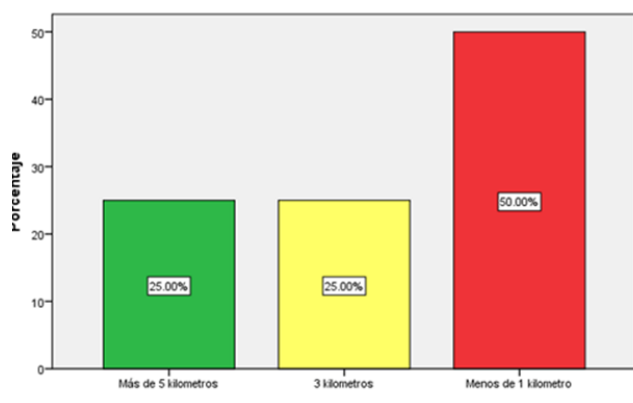
**Figure 5** Distribution of the nursing staff that, when conducting the home visit, find the correct address.

Sources: Survey applied to users and health personnel of a first level unit in Chilpancingo, Guerrero, Mexico; April 2017.



**Figure 3** Existence of situations in which you do not remember your scheduled appointments for you.

Sources: Survey applied to users and health personnel of a first level unit in Chilpancingo, Guerrero, Mexico; April 2017.



**Figure 6** Distance between the influence colonies and the center of health.

Sources: Survey applied to users and health personnel of a first level unit in Chilpancingo, Guerrero, Mexico; April 2017.

75% of nurses say that they visit the family planning program twice a month, while 25% say they perform 3 times a month. 50% carry out a home visit to the Vaccination program 3 times a month, while 25% do it once a month and 25% do not. 25% of nurses say they made visit program domiciliary Chronic Degenerative Disease

4 times a month, 25% do so 3 times a month, 25% is done 2 times a month, and 25% do not. 75% say they conduct home visits to the Pregnant Women Control program twice a month, while 25% do not. The program of healthy child and 150% of nurses say they made visit domiciliary the program once a month, while 25% is done n 3 times a month and 25% do 2 times a month. Regarding the treatment that the nurse provides to the user, 40% of the population mentions that their attention is excellent, although 10% say it is bad. According to the opinion of the people interviewed 60% said that is the home visit, and 40% know what you mean home visits. 40% suggest that the nurse has greater communication with the population, that is to say which is exclusive to the program, speak by phone and have more contact with users See Table 1. When doing the analysis between the variables, it was found that the sex is related to the type of PABS program carried in the health center (Pearson Chi-square = .013) and to the person who is the nurse responsible for your care? (Pearson Chi-square = .031). The variables associated with sex were entitled to be an institution (Kendall Tau-c = .689) and with which T here are situations where you do not remember your scheduled for (Tau-control Kendall c = 0.951 citations). Age was associated with being an institution of rechobabiente health (Kendall Tau-c = .836), and 1 PABS type of program that takes in the health center (Pearson Chi-square = .001) and with being a beneficiary of a federal program (Pearson Chi-square = .000)

**Table 1** Qualitative questions

Qualitative questions			
On a scale of 1 to 10, what rating would you give your nurse?	0	twenty%	Regarding the treatment that the nurse provides to the user, 40% of the population determines that their care is excellent.
	7	10%	
	9	30%	
	10	40%	
You What do you think of the home visit?	That it is good to perform	60%	According to the opinion of the people interviewed 60% said that is the home visit
	I do not know what it is about	40%	
What do you propose to improve it?	That there is an exclusive for the program	30%	40% of the population proposes that the nurse has more communication with the population
	Let them talk on the phone.	30%	
	That the nurse is more in touch with the population.	40%	

Source: Survey applied to users and health personnel of a First Level Unit of Chilpancingo; Guerrero, Mexico; April 2017

### Discussion

The home visit is a basic strategy of the PABS to promote, prevent, restore, maintain, and protect the health of the individual; However,

the execution is very difficult to verify, since it can be measured by two instances (users and nursing staff), of which it is mentioned that 93.4% of users report that they have never been scheduled home visits, however the nursing staff mentions that the patients who have undergone the home visit of which only 25% have almost always been found at home and 75% are rarely found. The nursing staff reports that there are obstacles to conducting home visits. Within the mentioned arguments are; the rugged terrain, the dispersion of the dwellings as well as distance and the non-availability of means of transportation; 75% of the staff mentions of its area of action only 50% of the streets are paved, 25% mention that the distance between the Health Center to the user's home is more than 5 kilometers, another phenomenon present and in potential growth is the insecurity and violence that has targeted Chilpancingo placing it in the first place at the national level and affects the health sector staff, 75% of nurses say that during the conduct of the home visit there is no type security, being its high-risk work area, not because of the work being done but because of the risks to which it is exposed (assaults, kidnappings, etc.), as a result of the insecurity present in the country, in the state, in the city and conurbated areas, it can be mentioned that the State of Guerrero is among the first places in violence and homicides, Chilpancingo has the first place at the national level as one of the cities with the highest insecurity according to the news, which could be a limiting factor for conducting the home visit.

Despite the fact that the home visit should be a priority and fundamental activity of the PABSS, there is no research background that indicates to what extent it is being carried out and what is the impact on the prevention and detection of health conditions and risks in the population. In the study conducted in Costa Rica in 2015, it was found that the guidelines for the improvement of the home visiting program are oriented in three areas: Health System, Home Visit Program and ATAP figure.<sup>15</sup> Unlike the results obtained in Chilpancingo de Los Bravo, Guerrero, Mexico in March 2017, it is reported that 75% of the nursing staff has not received training and this same percentage states that it requires a training course; while the 25 % if you have received, mention that an intensive home visiting course is important and necessary. The study from Tixtla, Guerrero, Mexico mentions that an important part of the population decides to wait for the visit, the intervention strategy raised the percentage of complete vaccination schemes,<sup>16</sup> differing from our research conducted in which only 50% of nurses mention that they visit the Vaccination program 3 times a month, while 25% say they perform 1 time a month and another 25% say they never do it. The domiciliary visit seen from the approach of its approach is a guarantee of the care of the individual and family, however at least the results obtained from this research 82%, refer not to receive the home visit, and in this contradiction there are two elements which are important to do the analysis; the inhabitants say they do not receive it and the health personnel says they can do it, probably this could be the axis of the analysis and discussion, posing the following questions; What is done? What is recorded? Are there family records? Are there genomapas? How is the control carried out and what evidence exists that the home visit is being carried out? The importance of the domiciliary view as a measure of education for the prevention of diseases should be strengthened, both in the field of practice and in the research field in order to mark the strategies to achieve the objectives outlined Program.

### Conclusion

To carry out the research project, municipal health support was requested, requesting the approval of the community field to carry

out the activities, Subsequently, the approval of the health center coordinator was obtained, and there was no problem in providing the required information with regard to the collection of information, 60 daily surveys were applied in different colonies assigned to the health center, thus covering both shifts. During the data collection, a large part of the population studied was reluctant, despite being identified, since the city of Chilpancingo is currently the target of crime, which justifies distrust of the interviewers. Research in this field is scarce, it is based on the idea that being inside the basic package is already being carried out, however in reality many doubts arise about its execution, about its impact, stating that no information was found in the Health center that evidences the results of follow-up through the home visit.

## Suggestions

The results of this research give rise to intervention projects that focus on the needs of the nursing staff as well as the requests of the users of the health center. For this reason, it is a priority to work in several areas aimed at training nursing personnel and users about the home visit and its importance. In addition, decision-makers must make public policies that strengthen the prevention of health problems and follow-up through interventions made during the miciliaria visit; likewise, promote the hiring of trained and sufficient personnel that covers the programs offered by the first level units that translate into better health care for the population and therefore a higher quality of life.

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None.

## Conflict of interest

The author declares there is no conflict of interest.

## References

- Galindo Cárdenas, Leonor A, PENA, María Eugenia Villegas, et al. Impacto De La Visita domiciliaria Familiar En El Aprendizaje De Los Estudiantes De Medicina En El Área De Pediatría Social. *Interfac Comucacitió Saúde Educatió Brasil*. 2013;17(46):649–660.
- Solís Cordero K, Guevara Francesa G. Programa de visita domiciliaria del sistema de salud costarricense: lineamientos para su mejora. *Revista Electrónica Enfermería Actual en Costa Rica*. 2015;18(29):1–3.
- Ruelas, González MA, Guadalupe. Modelo De Atención Integral En Salud Para Adultos Mayores Maltratados, Cuernavaca, Morelos: INSP. 2013. p. 1–24.
- Vaiz Bonifaz Rosa G. Enfermería Profesional En La Prevención Y Control De La Diabetes Mellitus, En El Primer Nivel De Atención. Tesis de post-gradado, Universidad Autónoma de Nuevo León. 1991. p. 1–76.
- Calderón Ortiz R, Mejía Mejía Jesús. Estrategias de contratación permanente dentro del programa de vacunación universal. *Salud Pública*. 1996;38.
- Universidad Alas Peruanas. *Introducción a los modelos y teorías de enfermería, 2008*. Disponible en: Consultado: 04 de noviembre del; 2016.
- Sánchez MA, Aparicio RV. Enfermería Comunitaria. España: Mc Graw-Hill7 Interamericana: 2011. p. 3.
- Smeltzer SC, Bare BG. Enfermería Médico-quirúrgica. España: Wolters Kluwer: 2012(12):1–2.
- Sánchez MA, Aparicio RV. *Ibid*. 2010. p. 9.
- Galdame Martínez HG, Visita Domiciliaria Como Una Herramienta Para La Detección De La Violencia Hacia El Adulto Mayor. *Enfermería Global*. 2011;16(17).
- Sánchez MA, Aparicio RV. Enfermería Comunitaria. España: Mc graw-Hill7 Interamericana. 2011;(3):204–210.
- Cubillos X. Visita domiciliaria integral para actuar en salud familiar. *Revista Biomédica Revisada Por Pares*. 2007;7(7):e949.
- Visita domiciliaria, Enfermería. Disponible en: Consultado en. 2016.
- Ministerio de Salud Pública y Bienestar Social, Guía de visitas domiciliaria. Paraguay, Diciembre 2012. p. 9.
- Solís Cordero K, Guevara Francesa G. Programa de visita domiciliaria del sistema de salud costarricense: lineamientos para su mejora. *Revista Electrónica Enfermería Actual en Costa Rica*. 2015;18(29):1–3.
- Calderón Ortiz R, Mejía Mejía Jesús. Estrategias de contratación permanente dentro del programa de vacunación universal. *Salud Pública*. 1996;38:1–3.