

Revisoning Postpartum Care in The United States: Global Perspectives

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Abstract The postpartum period is defined as beginning one hour after delivery of the placenta and continuing for six weeks, an arbitrary period of time constructed by the American medical system. Traditional postpartum care in the United States consists of daily hospital visits for two to four days, and a follow-up visit with a provider six weeks later. Many women feel unprepared for this transition into parenthood due to a natural focus on pregnancy and childbirth, and less emphasis on postpartum and newborn care issues. After childbirth, a woman is vulnerable to hormonal changes, feelings of inadequacy and uncertainty in taking care of her newborn, changes in her primary relationships, and exhaustion from disrupted sleep patterns. Issues specific to this time include insufficient support with breastfeeding leading to early cessation, postpartum depression, and lack of social support. In addition, women may suffer from short or long-term discomforts, such as backache, perineal pain, little to no sexual desire, or bowel and urinary issues. Other countries are known to provide considerably more postpartum support to women and their families. An exploration of traditional practices for the postpartum period from selected countries such as the Netherlands, China, Bali, and India, can provide insights for restructuring American postpartum care in this era of health care reform. The conceptual framework guiding this inquiry is rooted in comparative ethnography. The literature review revealed common postpartum concerns for women across cultures and unique concerns specific to the current American system of postpartum care. Honoring the postpartum period by providing women with the essential attention, education and nurturing they need will influence both the short term and long term health of women and their families. This inquiry will provide global perspectives of postpartum care and suggest a revisoning of postpartum care in the United States. (297 word count)

Chapter 1: Statement and Significance of the Problem

Introduction

The postpartum period is considered to begin one hour after delivery of the placenta and end approximately six weeks later. After 40 weeks of pregnancy, with an emphasis on prenatal care, preparation for birth, and assistance during childbirth, women and their families return home with little, if any preparation for what to expect and how to care for their baby and themselves. Traditional postpartum care in the United States consists of daily hospital visits for two to four days, and a follow-up visit with a provider 42 days or 6 weeks after discharge. After 40 weeks of attention given to prenatal care, we expect healing to occur in 42 days with little to no contact from a healthcare provider. While it is expected that many women will have family and friends to help them, this is not always the case, and there remains a lack of professional assessment and support. The postpartum period is a big void in healthcare within the United States. It is given little attention, with most women and their families left alone to navigate this new territory (Albers, 2000). Cheng, Fowles, & Walker (2006) state that most research has focused on postpartum depression and breastfeeding, but there is still inadequate data on the needs of postpartum women.

While each source of data may not represent the entire population, studies have collected the opinions of mothers and data pointing to a need for restructuring the system of postpartum care in the United States. A cross-cultural review of traditional practices for the postpartum period from selected countries such as the Netherlands, Bali, China, and, India will provide further insights for this restructuring. Looking at the different views of the initial postpartum period of 42 days, as well as, systems of support, nutrition, healing practices, and rates of depression, will shed light on the deficits and possible improvements for the current US healthcare system. At this time of healthcare reform in the United States, it is a good time to reevaluate our priorities and revise our system of maternity care to better suit the needs of women and their children.

The Netherlands has long been held up as a model of humane, sensitive, and effective maternity care. In the Netherlands, midwives provide the majority of maternity care, where 40% of women stay low-risk throughout their pregnancy and 30% give birth at home. This model of maternity care offers an example of effective and sensitive prenatal and postnatal care (Wiegers, 2006). Ninety percent of Dutch women, regardless of whether they gave birth in the home or hospital, receive in-home postpartum assistance provided by a midwife and a maternity care assistant (MCA). In addition to the breastfeeding support and assistance with the integration into this new phase of life, the care that is provided in the Netherlands, helps with early detection of health problems in the mother and baby, reducing readmission into the hospital and cutting healthcare costs (Wiegers, 2006). Comparatively, a woman in the United States is expected to recover from childbirth in six weeks, including the healing of her body, integration of strong emotions, adjustments to new roles, decisions about her workplace and the resumption of her daily activities before this time (Albers, 2000). The description of postpartum care in the Netherlands is one example of lessons that can be learned from a cross-cultural comparison.

Scope of the Problem

In 2009, there were 4,136,000 live births in the United States (CDC, 2007), and therefore a corresponding number of women experiencing the postpartum period. The maternal mortality rate in 2003 was documented as 12.1 per 100,000 births. The infant death rate in 2007 was 8.2%, with 26,200 in total. In 2007, the United States was ranked at 41 for maternal mortality, estimating this to be 1 death out of every 4800 women who give birth (Gosik, 2007). Ireland took the lead with the lowest rate of maternal mortality, followed by Bosnia, Hersegovina, Italy and Greece (Gosik, 2007). These statistics point to the major problem and deficit in perinatal care in the United States. For a developed nation, America's statistics for maternal and infant morbidity and mortality do not show any improvements for a country with scientific, medical and financial advancement. Ten to fifteen percent of American women will experience postpartum depression, which is linked to inadequate support (Joy & Contag, 2010).

Kantora, D'Angelo, Phares, Morrow, Barfield, and Lansky (2007) reported areas of increased need for postpartum women according to the findings in the 2000 PRAMS survey. See Table 1-1 below for a list of the 6 themes highlighting the postpartum needs of women based on their comments in this survey. There is little attention placed on the postpartum period in practice and research. The American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) specify a guideline of care for newborns, but no formal guidelines exist for women aside from the six-week follow-up visit after childbirth, and a possible two-week visit after a cesarean delivery

(Kantora et al., 2007). The guidelines of the AAP and ACOG will not be reviewed here, as they are beyond the scope of this paper. As displayed throughout this review of literature, women are unsatisfied with their postpartum care, have lingering health problems, feel unprepared and overwhelmed, and a large percentage of them end up depressed during this time when the expansion of a family for most is thought to be one of the most joyous and positively transformational experiences in one's life.

Table 1-1. Six Major Themes in the PRAMS Study

Findings of the PRAMS Study: Major Themes Identified: Listed in order of frequency: 1. Need for social support 2. Breastfeeding issues 3. Newborn care; lack of education 4. Need for help with postpartum depression 5. Perceived need for extended postpartum hospital stay 6. Need for insurance coverage to include the postpartum period
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Significance to Women's Health

Martha Ysha Oakes (2003), says "42 days for 42 years," stressing the importance of how women take care of themselves in the first 42 days after childbirth affects their health for the next 42 years. This is the premise of many cultural rituals and practices used during the postpartum period around the globe (Eberhard-Gran et al., 2010). *Listening to Mothers*, a report of a US survey of women's childbearing experiences, gives us insight into the problems most encountered by women during postpartum. Issues listed in the table below were the top 5 complaints of women that persisted for at least 6 months postpartum (Declercq, Sakala, Corry, Applebaum, & Risher, 2002).

More than seven out of ten women reported that they never consulted a health professional for help with those problems mentioned in Table 1-2 (Declercq et al., 2002). The focus moves from oneself to the infant in the postnatal period, leading to self-neglect and an increase in anxiety (Albers, 2000). According to the responses in *Listening to Mothers*, women feel abandoned after months of attention given to their health during pregnancy. Women reported wishes for more in-home care, education and resources (Declercq et al., 2002). Accordingly to some literature, many women are not fully recovered at six weeks. Many health problems can persist into the first year of motherhood or even longer (Albers, 2000).

Table 1-2 Listening to Mothers Report (2002)

Listening to Mothers Report (2002)

Top five complaints:

1. Physical exhaustion
2. Sore nipples and breast tenderness
3. Lack of sexual desire
4. Backache
5. Painful intercourse

Other common complaints:

- Perineal pain
- Bowel problems
- Frequent headaches
- Urinary problems

Significance to Midwifery

The American College of Nurse-Midwives, ACNM, (2003) acknowledges the need for changes in the current system in their position statement entitled *Depression In Women*. While the position statement speaks of the national issue of depression for both men and women, they discuss the prevalence among women of the childbearing ages 25 to 44 and the increased rates of postpartum depression. The ACNM (2003) states that CNMs and CMs should understand the dynamics of, impact on, and resources for postpartum women. Midwives are in a critical role to screen women prenatally that may be at an increased risk of suffering with postpartum depression, as well as education women of what to expect after childbirth. This position statement addresses the need for public policies to increase the number of postpartum visits for all women (ACNM, 2003). In addition, the *Core Competencies*, states the midwife's role in maternal and newborn care afterbirth including assessment, education, screening, and management of common problems and discomforts (ACNM, 2008). The ACNM is working to influence the goals set in *Healthy People 2020* (Office of Disease Prevention and Health Promotion, 2010). However, among the objectives set in Healthy People 2010 and 2020 there is no mention of postpartum care in the goals established for changing maternal and infant mortality and morbidity (Office of Disease Prevention and Health Promotion, 2010).

The Midwives Alliance of North America (MANA) lists the midwives responsibility and expected skills during the postpartum period in their *Core Competencies for Basic Midwifery Practice* (MANA, 1994). MANA (1994), recognizes the midwives role in understanding the causes, symptoms, treatment, and need for referral for common maternal discomforts and potential postpartum problems of the mother and baby. The Certified Professional Midwife (CPM) assists the women with breastfeeding and newborn care. The CPM acknowledges the emotional, psychosocial, sexual

variations and nutritional needs of a new mother and supports her in these transitions (MANA, 1994). A CPM that provides homebirth services in Philadelphia, PA, shared that she visits the woman 3 times in the first 2 weeks; in the first 24 hours, again at 3 to 4 days, and then at 7 to 10 days. The woman is offered a 2 or 3 week visit in the CPM's home office, and then wraps up the postpartum care at 4 to 6 weeks (anonymous interview, 2010). The timing of the visits offered by this CPM is congruent with the guidelines suggested by the World Health Organization, WHO, (1998 and 2006), and provides a continuity of care seen in the Netherlands's system. Whether a CPM or a CNM, midwives can play a valuable role in meeting the needs of women during the 42 days after childbirth.

Albers (2000) mentions two ways in which midwives can contribute to changing the way we care for women during the postpartum period. She suggests that midwives can recreate the patterns of postpartum care in their practice protocols and gather data from women cared for by midwives in the United States. Data collected by midwives can illustrate the issues faced by healthy, low-risk women, shedding light on their needs, and illuminating the even greater needs of those under obstetrician care (Albers, 2000).

The International Confederation of Midwives (ICM) is an organization with 101 Member Associations in 90 countries dedicating to supporting and representing midwives around the world and securing women's rights and access to midwifery care throughout the childbearing year (ICM, 2011). They are involved in a movement toward safer motherhood, along with the WHO. The ICM has several position statements regarding midwifery care practices and current issues in women's health care. According to Catherine Smith (2011), ICM's Technical Midwife Advisor, ICM does not have a position statement specific for postpartum care, and the ICM is currently revising their global standards for midwifery care, which includes postpartum care (Smith, 2011). Midwives around the globe are working to improve women's health and maternity care through the entire childbearing year, and making themselves more accessible to influence positive and great change (Mancuso, 2011).

Chapter 2: Review of Literature & Conceptual Framework

Conceptual Framework

A conceptual framework is the theoretical rationale and inspired concepts that drive and organize a particular study (Polit & Beck, 2008). It combines facts, observation, and experience into a theory that underpins the research. It brings order to research findings, making them meaningful and applicable. Whether implied or clearly articulated, the theories and conceptual model guide the research and keep the doorway of theory building open to new levels of possibility.

The impetus that led to this review of literature stems from years of supporting women during pregnancy and postpartum. Observing the magnitude of vulnerability, change and struggle often experienced by women during the postpartum period, revealed their needs for more nurturing, education and support. One vision for meeting the needs of women during postpartum involves their own adoption of best postpartum practices learned from other cultures, along with increasing the attention given to them by childbirth professionals such as, postpartum doulas, nurses, lactation consultants, and midwives during the 42 days after childbirth.

The conceptual framework of this study is the comparison of postpartum practices used in selected countries with those in the United States. This cross-cultural comparison will illuminate the important aspects of postpartum care, contributing to the revisioning of care given in the United States. Looking at the high level of maternal morbidity and mortality in the United States, it appears that women are not given the care they need (Albers, 2000). Long-term issues that plague many women might be avoided with adequate follow-up care after childbirth (Albers, 2000). A look around the globe shows that most, if not all cultures have a set of practices and guidelines for the postpartum period (Eberhard-Gran, Garthus-Neigel, Garthus-Niegel, & Eskild, 2010). In many cultures, the postpartum period is recognized as the first 40 or 42 days after childbirth. During this time the mother and baby are seen as vulnerable, and are given nurturing care through custom or formal health care systems. Special diets, isolation, rest, and assistance for the mother are key elements found in the care practices of most cultures (Eberhard-Gran et al, 2010). The body needs healing and rejuvenation after the incredible physiological changes that occur over the 40 weeks of pregnancy, as well as, the laborious process of childbirth.

Childbirth may be the most significant experience in a woman's life. It is followed by a tender period of adjustment to the new beginning of parenthood whether it be the first child, second, or more. The anatomic and physiologic changes in pregnancy occur over approximately 40 weeks, while the initial recovery takes place in just 40 days (Albers, 2000). Immediately after childbirth, a woman's body begins the journey of returning to its nonpregnant state. The epithelial lining of the uterus begins to restore itself at 2 to 3 days postpartum (Blackburn, 2007). The process of involution technically refers to all the organs and structures of the reproductive tract, but is mostly used when referring to the process of the uterus reorganizing and shedding the decidua/endometrium and the exfoliation of the placental site (Varney, 2004). At around 16 days, the endometrium has restored itself, but the healing of the placental site takes approximately 6 weeks (Blackburn, 2007). By the eighth week postpartum the uterus returns from its weight of 1000 grams immediately after delivery to its nonpregnant weight of 70 grams (Blackburn, 2007). As the uterus heals and decreases in size, it returns to being a pelvic organ by the tenth day after birth. The cervix remains dilated 2 to 3 cm for

about 1 week and the external os regains its nonpregnant form by 4 weeks postpartum (Varney, 2004). The vagina never returns to its nonpregnant state after the first child, but slowly heals, regaining rugae by the third week and tone over time. Vaginal epithelium is restored by 6 to 10 weeks. Decreased lubrication and any trauma from lacerations or an episiotomy can lead to discomfort with sexual intercourse. The broad and round ligaments regain their nonpregnant length and tone by the end of the 6-week postnatal period. The breasts also change, engorging with breastmilk after the first few days and adapting to the supply and demand of breastfeeding (Varney, 2004). For most women, despite the anatomy and physiology returning to its nonpregnant state, full recovery is not complete in these 40 days. As shown by the studies in this review of literature, many problems can persist for several months or longer. The way in which a woman tends to her recovery as well as her baby may affect her length of recovery, as well as her health and well-being in the future (Oakes, 2003).

Beyond the physical changes and recovery, are the adjustments required on psychological, interpersonal, and occupational levels. Women must adopt a new identity, as her relationship to herself and her primary relationship change (Albers, 2000). After hospital discharge, a woman in the United States may not see or speak to a midwife or obstetrician for up to 42 days. The follow-up care in the United States takes place at a standard office visit at 6 weeks, after the most intense hurdles have been navigated. In some populations, this 6 week follow-up appointment is not attended by a significant number of women, with particularly high no-show rates in certain populations. In many clinical practices, the focus of this visit is contraception, leaving little time to allow the woman to tell her birth story or discuss the difficult waters she has traversed during the last 42 days. Although changes continue beyond the first 6 weeks, it is during this time that women are most vulnerable to issues with breastfeeding, depression, and pain related to delivery (Declercq, Sakala, Corry, Applebaum & Risher, 2002). Another consideration is whether just increasing the number of office or home visits a woman receives during the initial 6 weeks postpartum is enough to fulfill her needs. More ineffective care does not make it effective, hence the need reconceptualizing postpartum care in America. A look into traditional postpartum practices of other cultures and current research may reveal that the quality and type of support a woman receives is as important as the quantity. Exploring the definitions of culture, as well as the practices within them, will help in understanding how to develop a new system for America and implement change.

According to Foster (1962), culture may be defined as “the common learned way of life shared by members of a society. Consisting of the totality of facts, techniques, social institutions, attitudes, beliefs, motivations and systems of values to a known group (sic).” In a broad sense, culture may be seen as Dehlot (1992) shares “to mean the totality of the different domains of life and their interconnections,” or as Jekayinfa (2001) states, “the total repertoires of human actions which are socially transmitted from generation to generation.” The United States is a *melting pot* of cultures in the diversity of citizens who were born here and those who have emigrated from other countries. The culture of the United States is defined mostly by the cultivation of the industrialized world of science, medicine, and finance.

The biomedical model dominates health care in America. Within this biomedical culture of western medicine are science, technology, and traditions that shape its values and actions. This biomedical culture is based in science and a concept of time that tends to be more linear and compartmentalized than what is seen in other non-Western cultures (Dehlot, 1992). Aside from an

abstinence from sex, the focus of the 6-week postpartum period is viewed very differently in Western and non-Western cultures (Dehlot, 1992). It is interesting to note that non-Western cultures have little to no incidence of postpartum depression (Winikoff, Beverly, 1992). Another difference between Western and non-Western cultures is their perceptions and relationship to time.

Dehlot (1992) brings up an interesting perspective when comparing the different relationships and perceptions to time in Western and non-Western cultures. She speaks of *institutional time* (the daily, weekly, and yearly cycles of society) and the issue of periodicity. Periodicity is a term used to describe the essence of the Periodic Table in chemistry. It describes how the table is built of repeating patterns that conform to certain rules (webchem.net). Western women are often constrained by with the pressures to perform certain tasks in strict urgent parameters of time. In the postpartum period, it is rare that a Western woman lets go of this relationship to *institutional time*. Non-Western approaches to the postpartum period support the withdrawal from this *institutional time*, with an emphasis on the woman getting rest and being with her infant (Dehlot, 1992). Herein lies a fundamental difference in Western and non-Western approaches to postpartum healthcare. It may be that adopting this shift of time and expectations of the woman into the Western medical system during postpartum, in addition to an increase in care during the first six weeks could improve women's health and satisfaction during the sacred time following childbirth. An important question to ask is whether we can change the biomedical culture's concept of time for this window of time in a woman's life, and if so how. It is important to acknowledge that the biomedical culture along with policy makers are currently setting the standards for postpartum care in the United States. Looking at other healthcare systems approaches to the postpartum period may shed light on possibilities of remodeling the current system in the United States.

The World Health Organization (WHO) put out a guide to postpartum care in 1998. In this report, they acknowledge postpartum as a neglected area of maternity care. The majority of maternal deaths and disabilities occur during the initial 6-week postpartum period, and early neonatal mortality is on the rise (WHO, 1998). In 1998 the infant mortality statistic was listed as 7.2 infant deaths per 1000 live births, totaling 28,325 deaths (Matthews, Curtin, & MacDorman, 2000). A more recent statistic shows the infant death rate in 2007 was 8.2%, with 26,200 in total (Gosik, 2007). These statistics show only a slight improvement in almost ten years. In 2006, the WHO put out another guide that covered the full spectrum of the childbearing year. This new practice guide is directed at the integrated management of women and newborns. The 1998 guide was specifically for postpartum care, covering issues and recommendations in greater detail. While this guide has not been updated for 13 years, we also have not seen a greater improvement in postpartum care as a result of the WHO's proposals for change.

In 1998, the WHO suggested an increase in the number of postpartum visits offered to women during the first six weeks after hospital discharge. Although there is no consensus on the optimal timing or number of home visits a women and her infant should receive, the WHO (1998) suggests intervals such as, 6 hours, 6 days, 6 weeks, and 6 months. They stress the importance of access to care, more than rigidity to these exact intervals. The 2006 guide suggests 1 visit in the first week, preferably in the first 2 to 3 days, and then again at 4 to 6 weeks (WHO, 2006). While more research is needed to assess the needs of women and the value of home visits, The WHO (1998) suggests the following essential components to postpartum care, listed in Tables 2-1, 2-2, 2-3. The WHO

recognizes the forty-two days after childbirth as a special phase that requires special attention and care in all cultures and societies.

Table 2-1. WHO: Essential Components of Postpartum Care

1. Prevention, early detection and treatment of complications and disease
2. Provision of advice and services for breastfeeding
3. Birth Spacing
4. Immunization
5. Maternal nutrition

Table 2-2. World health organization: Needs of Women during Postpartum

Needs of Women

In the postpartum period, women need:

- Information/counseling on
 - Care of the baby and breast feeding
 - What happens to their bodies –
 - Including signs of possible problems
 - Self care – hygiene and healing
 - Sexual life
 - Contraception
- Nutrition
- Support from – health care providers
 - Partner and family: emotional,
- Psychological
- Health care for suspected or manifest complications
- Time to care for the baby
- Help with domestic tasks
- Maternity leave
- Social reintegration into her family and community
- Protection from abuse/violence.

Women may fear:

- Inadequacy
- Loss of marital intimacy
- Isolation
- Constant responsibility of caring for the baby and others

Table 2-3. WHO: Needs of Newborns

Needs of newborn infants

In the postnatal period newborn infants need:

- Easy access to the mother
- Appropriate feeding
- Adequate environmental temperature
- A safe environment
- Parental care
- Cleanliness
- Observation of body signs by someone who cares and can take
- Action if necessary
- Access to health care for suspected or manifest complications
- Nurturing, cuddling, stimulation
- Protection from
 - Disease
 - Harmful practices
 - Abuse/violence
- Acceptance of
 - Appearance

Ethnography is a type of qualitative inquiry used in anthropology to study human cultures, describing and interpreting cultural behavior. Fieldwork is used to understand the culture and ethnographic written text refers to how the culture is communicated and portrayed, (Polit & Beck, 2008). Polit & Beck (2008) say, “ Culture is inferred from the words, actions, and products of members of a group.” (p. 224). An ethnographer approaches their study with the assumption that every human group eventually evolves into a culture that directs its members’ outlook on the world and influences their actions and experiences (Polit & Beck, 2008). Most ethnographers prefer to study the culture by engaging with the people of the cultural group through fieldwork, rather than through outside interpretation (*etic perspective*). They strive to obtain an *emic perspective*, which is the insiders’ view, and comes from studying how the members of a culture view their world (Polit & Beck, 2008). Ethnography requires study that takes place over long periods of time. The strategy, known as *participant observation*, is used as the ethnographer spends time living within the culture, developing intimacy and working along side the members of the culture day after day. Data is gathered through observations, interviews, records, charts, photographs, diaries and letters. They might also use assistance through the use of a *key informant*, which is someone who helps them understand and interpret their observations and experiences (Polit & Beck, 2008). Introducing the findings in one culture to another can be challenging, taking place over time just as a culture originally develops.

This inquiry will identify the needs of postpartum women and compare how these needs are met in the United States and in other countries. In health care research, ethnography gives us information about different cultural health beliefs and practices, and can bring understanding to cultural behaviors regarding health and illness (Polit & Beck, 2008). Adapting the current model of care in America with the addition of traditional practices around the world may not be easy. While not all cross-cultural ideas will work well or easily in America, they may offer insight into the needs of postpartum women. In the *melting pot* culture of America, introducing new cultural practices may not

integrate amongst the entire population. In places, such as the Netherlands, where everyone has basic health insurance, with options for private and supplemental insurance plans, most women receive the same opportunity for care after having a baby (Exter, Hermans, Doslak, & Busse, 2004). In America, insurance is an individual responsibility with a range in price and coverage, which makes a big difference in who can access it and what services are provided. Exploring different cultural systems will help to pinpoint the strengths and weaknesses of the current postpartum healthcare system in America.

Maternity care in the Netherlands provides a system that values in-home postpartum care. More than 90% of women who give birth in home or in the hospital, receive maternity care assistance postpartum (Wiegers, 2006). Forty percent of all pregnant women remain low-risk and are cared for by a midwife. The standard care for low-risk women is an average of eleven or twelve prenatal visits, one or two ultrasounds during pregnancy, childbirth at home with a midwife and a maternity care assistant (MCA), or in the hospital with a midwife and a nurse. After a normal birth, women return home from the hospital within a few hours, followed by 5 or 6 home visits by the midwife within the first 10 days, and the help of the MCA for 6 hours a day for 7 or 8 days total during the initial 42 days. The midwife completes postpartum care at 6 weeks (Wiegers, 2006). The MCA is expected to be at the woman's home when she returns from the hospital. The care of the MCA is part of the standard insurance package (Wiegers, 2006). The MCA completes a 3-year mid-level vocational training. She reports to the midwife on the health status of the mother and infant. The goals of postpartum care in the Netherlands are; monitoring the health status of mother and baby, breastfeeding assistance, health education, and providing tangible assistance with household chores and a sensitive and nurturing presence of support. The MCA becomes part of the family during this time, helping to ensure that the mother gets enough rest, performs household tasks, helps with other children and receives visitors.

Research has shown that 6 hours of care was the minimum that helped a woman establish a confident level in caring for her baby (Wiegers, 2006). Dutch women and their caregivers are satisfied with this system of postpartum care, which has shown positive effects on maternal and infant well-being. It is valuable for the United States to see a system with positive results without the rituals of other cultures that might not fit into the dominant biomedical model of care. However, for immigrant women living in the United States and for those who become influenced by such rituals and practices, it is important to be aware and honor the personal choices of such patients. Learning about the postpartum cultural practices in Bali, China, and India are a sampling of differences that may shift the American view of caring for women and babies.

The ethnographic report from Robin Lim, a midwife who has lived and worked in Bali for over a decade, provides observation and personal experience into Balinese postpartum practices. In the Balinese culture, during the first 42 days of the postpartum period (*sebel*), the woman and the baby do not leave the compound. A compound is made up of several homes within a certain area usually inhabited by family members, but may consist of family and friends. Those living in a compound live communally and support each other in times of need, as seen in the postpartum period. It is considered spiritually unsafe to leave the compound, based on beliefs that they must protect the baby from the demons. During the first three days, or until the umbilical stump falls off, the woman is not allowed in the kitchen. The kitchen is considered sacred, and therefore a woman should not enter it while she is bleeding after birth or during menstruation (Lim, 2010). This also keeps a woman from

jumping back into routines of cooking and cleaning (Lim, 2010). While the umbilical cord is still attached, the Balinese believe that an ancestor who has not taken reincarnation is still taking care of the child, who is considered to be half in the spirit world and half on earth. Once the stump falls off, the child is released into the earthly care of the family and community (Lim, 2010). During the first few days after birth, the woman is encouraged to eat porridge, called *burbur*, made of rice and vegetables. After the first 3 days, a cleansing ritual is performed so that the parents can go into the kitchen (Bali Spirit, 2010). Until the umbilical stump falls off, the woman does not wash her hair, the men of the family do not help with village clean up or up-keep the temples, and the entire family does not attend any celebrations or visit the temple (Lim, 2010). Postpartum is seen as an unclean time, especially while the woman is bleeding, and being a family event, the entire family stays away from the temple during this postpartum period (Lim, 2010). There is a prayer ceremony after 12 days called *Ngelpas Hawon*, as well as, certain rituals for burial of the placenta and daily offerings made at the altar created and taken care of by the father. An altar is built for the umbilical stump, where it is placed once it has fallen off, along with flowers, fruit, incense, water, rice, cakes, and small money. The altar is hung above the place where the baby sleeps and honored on the new moon and full moon (Lim, 2010).

There is another ceremony after 42 days have passed and again after 150 days. After 42 days, the baby is fully welcomed into the family with a naming ceremony and the mother can resume her daily village life (Lim, 2010). After 150, a ritual (*Nyambutin*) is performed where the baby's feet are allowed to touch the ground for the first time. Before this time, the parents or other relatives and community members have held the baby at all times besides while he/she is sleeping. This ritual is to honor the earth and bless the child's life. Many details are put into this ritual, which is one of the biggest in one's lifetime (Lim, 2010). The Balinese culture is full of rituals that mark many significant turning points throughout life.

The Chinese culture implements philosophies and practices of Chinese medicine into the care for women during pregnancy and postpartum. Most remedies are started after the twelfth day postpartum, when the lochia flow has cleared. The next 30 days are referred to as "doing the month," during which women eat certain foods, do not bath or wash their hair, and do not expose themselves to cold or wind (Holroyd, Twinn, & Yim, 2004). In the study by Holroyd et al (2004), some women reported using boiled ginger water for bathing and washing their hair, while others avoiding the bathing during the most crucial time of the first 12 days after childbirth. It may be that some of the rules around bathing developed at the time when people did not have access to bath in hot running water. The Chinese look at food, herbs, and certain practices as being hot or cold, and avoid that which is cold during postpartum. In these practices, as seen in most other cultures, the first 42 days are seen as a time for intense healing and rejuvenation. Foods that are both warming and cleansing to the body, such as ginger, vinegar, dates, chicken soup, fish soup, and pig trotters are consumed (Holroyd et al, 2004). Soup is made by boiling deer antlers and thought to give the woman her strength back. A woman is cared for and nurtured by her mother and/or mother-in-law. Under the influence of her elders, Chinese women today continue to practice some variation of "doing the month" (Holroyd et al, 2004). It is questionable whether modern culture will influence women to neglect these ancient practices believed to support greater health and well-being in the future.

Similar to Balinese and Chinese culture, Indian culture has specific foods and practices for pregnancy and postpartum. As in Chinese Medicine, Indians place food and herbs in the categories

of hot or cold. Pregnancy is seen as a hot condition during which foods that are cooling, such as ghee (clarified butter), milk, coconut and yogurt should be consumed (Choudhry, 1997). After childbirth, the woman rests at home during the first 40 days. During this time, she eats certain foods to help bring her body back into balance, avoiding cold food and water. She receives massage daily by her mother-in-law or midwife. She eats dried ginger, as it is thought to help control postpartum bleeding and cleanse the uterus. The midwife visits the home everyday, tending to the care of both mother and baby. Other women in the household will assist in caring for the infant. Cold baths and showers are avoided. Breastfeeding is viewed as good, but not initiated until the fifth day, as the colostrum is seen as indigestible or pus-like. This view varies among rural people and others from different parts of India (Choudhry, 1997). The aspect in this system of postpartum care most valuable to the American woman is the element of rest. The rest, nurturing care, and dismissal from daily chores and expectations offers a woman time to bond with her baby, tend to her own healing, and slowly integrate the new beginnings of this vulnerable and precious time after childbirth.

The fundamental similarities amongst the cultures of Bali, China, India, and the Netherlands is a mother's need for rest, proper nourishment, time to bond with her baby, and family and community support that assists her with achieving these needs during the first 42 days after childbirth. Adequate support helps a woman in the physical, emotional and spiritual aspects of postpartum healing. The rituals of the Balinese, while they may not be accepted by the mainstream American culture, reminds us that this time after childbirth is sacred and one that should be regarded with protection and gratitude. The principles of hot and cold seen throughout the cultures of Bali, China, and India, are important aspects of their traditional practices and may be accepted into American culture. It is unlikely that the particular foods used by these cultures, especially the Chinese, will become part of standard postpartum care in America, but the principles of eating warm foods and avoiding cold food and beverages can be applied within the context of most diets. Education is something that gets passed on from generation to generation in all cultures, and can be supplemented in America by professional resources. Implementing change into the American culture is something that will take place over time, beginning with the American woman's willingness to abandon her typical daily life, work and all its responsibilities, to rest and honor the 42 days after childbirth as a time to restore her own health and the health of her baby. The foundation of American culture strongly influenced by the biomedical model and that of *institutional time* previously mentioned may be hard to change without scientific evidence demonstrating the benefits, although the cultural beliefs about the long-term impact made by following certain guidelines during postpartum have been observed in for centuries. Most likely, changes in the system and procedures will precede others more influenced by the cultural practices of Bali, China, India, or other countries. See Table 2-4 for a comparison of Bali, China, India, and the Netherlands.

Table 2-4. Comparison of Postpartum Practices: Bali, China, India, The Netherlands

Country	Bali	China	India	Netherlands
Postpartum Support	42 days	42 days <ul style="list-style-type: none"> ○ First 12, no remedies, just rest ○ Next 30 called “doing the month” 	40 or 42 days	Six weeks (42 days)
Support	Women and men of compound	○ Mother or mother-in-law	Mother-in-law or midwife Daily massage	○ MCA and Midwife ○ 5-6 home visits in first 10 days ○ Help 6 hours/days for 7-8 days during six weeks Midwife completes PP care at 6 weeks
Diet	<i>Burbur</i> : Porridge of rice and vegetable first few days	○ Ginger vinegar, dates, chicken soup, fish soup, pig trotters (feet) ○ Soup of deer antlers for strength	○ Kitchari ○ Warm soups ○ Warming spices (ginger, cinnamon, mustard seeds, cumin) Avoid certain foods; nightshades, cabbages, beans, meats, hard cheese)	Nothing specific noted
Hot/Cold Beliefs	Warm foods	○ Yin/Yang ○ Warm foods ○ Avoid cold drafts or wind ○ Avoid showers, washing hair ○ Pregnancy is hot condition PP is cold condition	○ Pregnancy is hot condition ○ PP is cold condition ○ PP avoids cold water or cold food ○ Eats dried ginger Avoids cold bath and showers	Nothing specific noted
Rituals	○ Until cord falls off not allowed in	○ At home for 42 days ○ First 42 days	○ Daily massage ○ Period of	Nothing specific Goals of PP care ○ Monitor

	<ul style="list-style-type: none"> ○ kitchen ○ Cleansing ritual after 3 days ○ No hair washing ○ Whole family stays away from temple ○ Prayer ceremony at 12 days ○ Rituals with placenta ○ 42 days, naming ceremony ○ 150 days, ritual touching feet to ground for first time 	<p>seen as intense healing and rejuvenation</p>	<p>intense healing and rejuvenation</p>	<p>health status of mother & baby</p> <ul style="list-style-type: none"> ○ Breastfeeding assistance ○ Health education ○ Sensitive and nurturing presence of support ○ MCA helps with Mom getting rest, household tasks, other children, receives visitors (becomes part of the family)
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Key

PP=Postpartum

MCA= Maternity Care Assistant

Conceptual Map

Postpartum mortality and morbidity---Lack of appropriate postpartum support and follow-up services in the United States--- Void of adequate postpartum care--- The first 40 to 42 days after childbirth---Vulnerability of mother and infant---Traditional postpartum care around the globe--- Western vs. Non-Western culture---Explored practices in Bali, India and China---The Netherlands system of postpartum care---Proposals for change---Visions for a revised system of women’s postpartum health care

Problem

In the United States, follow-up care after childbirth is limited in scope and typically completed after the first 6 weeks. This current healthcare system lacks the support required to help a woman and her family adjust to their new roles and responsibilities, and more importantly to assist the women in her recovery of the anatomic, physiologic, and psychological changes after childbirth. The postpartum period follows one of the most significant life-changing experiences in a woman's life. In most cases women are not educated on how to prepare for this time, and are left alone to navigate the overwhelming waters of the initial 42 days postpartum. Although during pregnancy it is natural to focus on one's current needs and the preparation for childbirth, little emphasis is placed on informing women about what to really expect after giving birth. Many of the physical and emotional problems that women suffer from long-term, arise during the first 2 weeks postpartum, or within these 42 days. An increase in the attention and support women receive during this time may greatly affect their long-term well-being, as well as the health and well-being of her infant. The data gathered pertaining to women's expressions of their experiences and requests for more support tells us that the current system is inadequate for meeting their needs.

Review of Literature

Search Strategy

The main method used to identify and retrieve articles was through the online databases at the Paul Gutman Library at Philadelphia University. Google Scholar and general Internet exploration supported my initial searches, but all of the articles were retrieved through the library. The databases used were MD consult and Springer Link. Articles were found that supported the inquiry into the postpartum needs of women in the United States and other countries. Some of the studies explored past and current problems in the American system, such as by looking at the number of Emergency Department visits made in the postpartum period or the effects on self-confidence with in-home care provided to women of a low socio-economic status. Other articles provided information regarding cultural postpartum care practices from around the world, and models of healthcare that meet the needs of postpartum women, particularly in the Netherlands. Articles were found that documented women's opinions and experiences of postpartum care, giving weight to my inquiry proposals for changing the current postpartum healthcare system in the America. Postpartum depression appears to be the most researched topic during this stage of the childbearing year. Articles regarding the topic of postpartum depression were used for this inquiry, although, it is only a piece of the puzzle put together with this review of literature.

Key words: postpartum care, postpartum in China (United States, India, Bali, Netherlands), culture, postnatal care, early postpartum care, process of cultural change and postpartum rituals.

Challenges Faced by New Mothers in Early Postpartum Period: An Analysis of Comment Data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) Survey (2007)

This study took place in 20 states throughout the United States. The findings, based on the PRAMS survey, developed and funded by the Center for Disease Control and Prevention (CDC) intended to identify challenges that women face in the 2 to 9 months postpartum (Kanotra, D'Angelo, Phares, Morrow, Wanda, & Lansky, 2007). The authors commented on the small amount of attention given to maternal health in the early postpartum period. There is no formal care given to women before or after the 6-week postpartum follow-up visit, aside from a possible 2-week appointment added for those who delivered by cesarean section (Kanotra et al, 2007). The authors hoped that the insights shared by the participants would shed light upon areas of need for postpartum mothers, and that the findings would be used by healthcare providers, educators, and policy makers to formulate strategies and further assess new mothers' needs.

This quantitative study analyzed data that was gathered by the Pregnancy Risk Assessment Monitoring System (PRAMS) in a secondary analysis. Secondary analysis involves using data that had been collected in other studies in order to test new hypotheses or explore new relationships (Polit & Beck, 2008). The benefits of doing secondary analysis is that the process of data collection, which is typically very time consuming and collects more than is analyzed, is already complete. There is also a savings in cost, as some data can be purchased for 1% of its initial costs. Researchers run into some issues with secondary analysis, such as, working with data that is framed for a different purpose. Using another's research can be both resourceful but limiting. Kanotra et al (2007) states "PRAMS is an on-going population-based surveillance system that collects self-reported information on maternal behaviors and experiences before, during, and after the birth of a live infant." (p. 549). The researchers analyzed the responses related to postpartum care written in the free text comment data section on the back page of the survey.

PRAMS is well known for collecting quantitative data, however it also collects qualitative data by providing a section for additional comments. The data analyzed was from voluntary comments of those women who chose to share their thoughts and feelings. An open-ended question was used on the back page of the survey asking women to make any additional comments about the health of mothers and babies in the state that they live. Open-ended questions can give more depth and a personal perspective to the topic in question, however, they are also more time consuming and difficult to organize and analyze. Open-ended questions are usually organized into fixed categories, as was done in this study grouping the comments into six themes, listed below in Table 2-5. Although the comments were gathered in a qualitative way, the authors used a quantitative approach in their calculations and organization of the data.

There can be limits to using personal experience as a source of information in many areas of research and practice (Polit & Beck, 2008). Quantifying the responses, as in this study gives more weight to the themes extracted from the comments, as compared to, considering only one person's experience. Relying on personal experiences will always be as a large part of evaluating women's needs postpartum. After gathering data through personal experience, logical reasoning may be used as a means to apply the findings toward making change in clinical practice and the way we care for postpartum women and babies (Polit & Beck, 2008).

Women from 10 out of the 20 states that participated in the PRAMS study of 2000 wrote “back-page” comments that were analyzed in this study. The states were; Alabama, Florida, Hawaii, Louisiana, Maine, New Mexico, Ohio, Oklahoma, Washington, and West Virginia. Eligible mothers were selected using birth certificates. Up to 3 mailings were sent to these women 2 to 6 months after birth. Those that did not respond were contacted by telephone. PRAMS collected information from the birth certificate, as well as the comments page. Acceptable levels of reliability were achieved by a multistep coding process- segmentation of text, codebook creation, initial coding, assessment of coder’s reliability, codebook modification, and final coding. Four reviewers used the initial codebook to code the comments, and then used EZ–Text software to run a reliability comparison of the codes (Kanotra et al, 2007). The reliability scores were well above the minimum agreement level of 70%, with a range of 88% to 94%.

Three thousand, four hundred and seventeen of the 15,914 women who responded to the PRAMS survey of 2000 in the ten states wrote comments either in writing or over the telephone. Three hundred and twenty-four of the 3,417 wrote comments regarding postpartum care and experiences. The final sample was this group of 324 women, 2% of the total number of respondents to the survey. Because some women commented on more than one topic the final number of comments was 366. Women who commented about postpartum challenges were more likely to be \geq 25 years old, white, non-Hispanic, have more than a high-school education, married and not Medicaid recipients. This research gave women a voice to express their postpartum needs and used a narrative analysis to extract important themes from their original comments, and then categorized and counted them (Polit & Beck, 2008).

Although this study does not adequately represent all women who answered the PRAMS survey or all women in the states in which the survey was offered, it does provide useful guidance into further research of maternal postpartum health. It was a small final sample size relative to the primary study. The sample participants were limited to women who had a live birth, excluding those who had experienced miscarriage, fetal death, or stillbirth, but this does not lessen the findings that can apply to improving the care of women with a live newborn. Although this sample only represents a certain portion of the total population, there are anecdotal reports that support these findings. There was richness and depth to the comments reviewed in this study, and therefore it brings forth important inquiry into the challenges women face during postpartum. Further research will support and bring other insights into the concerns and challenges that women consider being the greatest during the initial postpartum period. The early postpartum period is a time when women are most vulnerable, and given the least amount of attention. The challenges or void of care mentioned in this study continues today in the United States, hence the importance of this inquiry for change.

**Table 2-5. PRAMS Study: Six Major Themes
(in order of frequency)**

1. Need for social support following hospital discharge (32%)
2. Breastfeeding issues (23.5%)
3. Newborn care; lack of education (21%)]
4. Need for help with postpartum depression (9.5%)
5. Perceived need for extended postpartum hospital stay (8%)
6. Need for insurance coverage to include postpartum period (6%)

Listening to Mothers: Report of the First National U.S Survey of Women’s Childbearing Experiences (2002)

This study was conducted in the United States, in order to survey women’s experiences of childbirth (Declercq, Sakala, Corry, Applebaum & Risher, 2002). It was the first national survey of its kind. It was developed through collaboration between Maternity Center Association and Harris Interactive, with the support of the Listening to Mothers Advisory Council. The survey explored women’s opinions, attitudes, feelings, and knowledge about their experiences during pregnancy and postpartum. It also included new data that had only been recorded at the clinical level. The new data included various practices such as; eating, drinking and walking in labor, the use of drug-free methods of labor pain relief, and birth position. They collected information about preparation for birth with childbirth education, the specialty of physician caregivers, and labor support providers. Outcomes such as postpartum morbidity and depression were included as well. The survey also documented data from the federal vital and health statistics system birth and death certificates. The intention for this survey was to shed light on women’s experiences during the childbearing year and areas that need improvement by listening to women directly. The Maternity Center Association’s focus on improving maternity care was the framework of this study.

The sample was drawn from the Harris Poll Online (HPOL) panel of U.S. adults, which were recruited from a variety of sources, including the HPOL registration website and offerings made by several other organizations. Telephone interviews and email questionnaires were used to gather data. Emails were sent to a sample of women, inviting them to participate in the survey, with direct links to the survey website. After a preliminary screening, those eligible were allowed access to the survey. Telephone interviews were conducted with a sample of women selected from recent monthly Harris telephone surveys, conducted between August 2000 and May 2002. Telephone interviews are less costly and convenient if the questions are short and not too personal, but may not be the best choice when interviewing low-income women who may not have a telephone. Previous personal contact can improve the dialogue of a telephone interview, making it a more useful strategy for data collection (Polit & Beck, 2008).

The survey was conducted on 1,447 online participants and 136 telephone interviews. The women were between the ages of 18 to 44, had to have given birth within the last two years (May 2000 through May 2002) and speak English. Those women who had multiple births, or whose child

was no longer alive were excluded from the study. Demographics, extensive review and the propensity score were used for accuracy and to eliminate or control for selection bias. A 10-question Edinburgh Postnatal Depression Scale (EPDS) was used to assess rates of postpartum depression. The Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report instrument was used in the assessment of depressive symptomatology. This instrument is the most commonly used scale to assess postpartum depressive symptomatology and identify at-risk mothers, however, the results do not give a diagnosis of postpartum depression. The EPDS has been used in many studies with well documented reliability and validity. Tables in the study showed the range of sampling variation that applied to percentage results for the survey. Statistical figures illustrated a 95% confidence level with sampling tolerance. According to Declercq et al (2002), “the chances are 95 out of 100 that the survey results do not vary, plus or minus, by more than the indicated number of percentage points from the results that would have been obtained had the interviews been conducted with all the persons in the universe represented by the sample” (p. 52). The procedures followed by Harris Interactive are designed to keep sampling errors, data handling errors, and interviewer recording errors commonly found in this type of study to a minimum.

This review will focus on the postpartum section of the survey. The main areas of exploration were the number of postpartum visits, physical well-being, mental health, and feelings during the weeks and months after birth. Just over 4 out of 10 women had one postpartum visit (43%), 1 out of 3 (30%) had 2 visits, and 1 out of 5 (20%) had 3 or more visits. One out of three (33%) of women felt that their needs were not met, nor did their maternity caregiver answer their questions during the postpartum visit. Women who had a cesarean delivery complained mostly of pain at their surgical incision site. Five out of six women (83%) who had a cesarean delivery reported pain at the area of their incision in the first 2 months postpartum, and 1 out of 14 (7%) women reported it as a problem at 6 months. Three out of four of all women complained of physical exhaustion (76%) and sore nipples (74%) as major problems. Over half of the women reported lack of sexual desire (59%) and backaches (51%), and 1 in 5 women reported painful perineum (41%), painful intercourse, bowel problems, urinary problems, infection, and frequent headaches during the first two months postpartum. Lack of sexual desire (16%) and physical exhaustion (11%) were the problems most likely to persist after 6 months. The online participants were given the Edinburgh Postnatal Depression Scale, showing 1 out of 5 women with scores indicating some degree postpartum depression. A high percentage of women expressed feeling “rewarded” (85%), “supported” (84%), “contented” (74%), “confident” (73%), or “clear-headed” (63%), while a less percentage mentioned organized and rested. One out of 4 women chose each of the negative responses. These selected negative responses, listed in range of high to low percentages, were feeling “tired” (93%), “messy” (60%), “unsure” (39%), “isolated” (35%), “sad” (35%), “discouraged” (26%), or “confused” (25%) (Declercq et al, 2002).

Listening to Mothers covered a full range of experiences and practices in the childbearing year. The population in this survey represents the mainstream medical culture of birth today, with most of the participants receiving physician care (85%) and some form of medical intervention during labor and birth. As a descriptive research study, this collection of data served to portray a real picture of women’s experiences in the childbearing year. This study provided an incredible foundation for future research into improving maternity care. While many women felt rewarded by becoming a mother, they also complained about the care they received postpartum. The findings in this could lead to the hypothesis of a critical piece suggested in improving postpartum care for women, which is

increasing the number of and the quality of postpartum care visits during the first 6 weeks to 2 months. It also illuminated the incidence of postpartum depression, which could be better addressed with an increase in the attention given to women during the first few weeks after childbirth. This study is a reflection of maternity care in the United States, however, the sample size did not include ethnic women who cannot speak English, and was limited mostly to those who use the Internet, which may keep these findings from being generalizable to the whole population. It is possible that those who are in a lower socioeconomic category may have worse experiences than those in this survey. Future research is needed to explore different cohorts of our population.

Postpartum Physical Symptoms in New Mothers: Their Relationship to Functional Limitations and Emotional Well-being (2008)

One thousand, three hundred and twenty-three women participated in interviews conducted at the time of enrollment for prenatal care, and 3 postpartum surveys in their homes at approximately 3 to 4 months, 9 to 12 months, and 22 to 24 months postpartum. Most women were single, U.S.-born, and African American with low income. One-third of the 1,323 women who responded to the survey, had less than a high school diploma and the overall mean age was 24 years old. The surveys explored the relationship between physical symptoms, functional limitations, and emotional well-being experienced by women during postpartum. The women received prenatal care at 9 community health centers located in Philadelphia, Pennsylvania between February 2000 and November 2002 (Webb, Bloch, Coyne, Chung, Bennett, & Culhane, 2008). Emotional well-being was assessed using the Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a reliable and valid instrument used in many studies of depression, including postpartum depression. Three questions in the survey asked about functional health status, concerning the effect of their physical health on their ability to work, care for their children, or perform general household chores. The responses were measured in terms of functional limitations in relation to childcare, daily activities (housework and shopping), and employment. A checklist of 13 possible symptoms (see Table 2-6 below) was included in the survey, which was then tallied according to the severity experienced using a point system (0-3 points). The points were added together and each respondent was assigned a total score, which was referred to as the postpartum “morbidity burden scale” (Webb et al, 2008). Women were then categorized in using this scale, and seen as having no morbidity burden (0 points), low (1 or 2), medium (3 -6) or high (7 or more) morbidity burden. To make the final analysis more manageable certain conditions were listed together. Refer to Table 2-6 and Table 2-7 for symptoms and findings. The *p* values reflect the levels of significance for gamma scores, and the degree of association between the severity of the condition and the presence of functional limitation (see Table 2-7).

Table 2-6. 13 Symptoms on Checklist of Possible Postpartum Symptoms

1. Fatigue or tiredness
2. Headaches
3. Nausea or vomiting
4. Backaches
5. Constipation
6. Hemorrhoids
7. Vaginal pain, discomfort, or discharge other than blood
8. Dyspareunia
9. Abdominal or pelvic pain
10. Frequent urination or feeling of having to urinate frequently
11. Inability to make it to the bathroom on time
12. Inability to control bowel movements
13. Breast soreness

Table 2-7. Postpartum Conditions: Severity, Functional Limitation, Depressive symptoms

Key:

- %R=percentage of respondents
- %F= percentage with functional limitations
- %D= percentage with Depressive symptoms
- p= p value for functional limitation

Condition	Never a problem %R/%F/%D	Minor Severity %R/%F/%D	Moderate Severity %R	Major Severity %R	Moderate or Major Severity %F	Moderate or Major Severity %D	P value %F	p value %D
Fatigue, headaches, nausea	49.0 13.7 17.4	23.1 18.0 19.99	20.02	7.7	30.4	27.9	0.001	0.001
Backache	56.9 14.6 18.3	18.3 21.9 17.8	15.2	9.6	28.4	29.3	0.001	0.05
Abdominal pain	89.0 17.2 20.3	4.7 35.5 25.8	4.4	1.9	37.3	26.5	0.001	n.s.
Vaginal pain or dyspareunia	89.6 17.2 19.2	4.5 30.0 25.0	4.2	1.7	38.5	43.6	0.001	0.001
Constipation or hemorrhoids	87.9 18.0 20.4	6.0 25.2 20.3	3.8	2.3	33.3	29.6	0.002	n.s.
Urinary or bowel problems	85.6 17.6 19.8	5.9 21.8 24.4	5.3	3.2	35.3	32.7	0.001	0.001
Breast soreness	92.1 17.8 20.8	3.9 40.2 17.3	2.7	1.3	34.0	28.3	0.001	n.s.

This study was part of a larger, prospective community-based study that examined the entire childbearing year. It was funded by the Centers for Disease Control and Prevention and The National Institute for Child Health and Human Development. As a cross-sectional study, the results presented were based on data collected during the interviews at 9 to 12 months postpartum. It is therefore difficult to apply the findings to the postpartum period from birth to 9 months. However, the conclusions drawn can offer suggestions for future research and have implications for clinical practice, as well as, being more economical type of study.

Interviewers were trained and attended weekly meeting with the project staff and principal investigator to minimized bias and misinformation. The results of this study showed a statistically significant correlation between physical symptoms, functional limitations and depressive symptoms. Two out of 5 women (45.5%) had at least one condition with moderate to major severity. Fifty-one percent of women complaining of fatigue, headaches and nausea since giving birth; 1 in 5 (20.2%) having moderate severity or major (7.7%) compared to minor severity (23.1%). The other most frequently reported physical problem was backache with almost 1 out of 4 women reporting this as either moderate (15.2%) or major (9.6%) severity. Their functional limitations and both measures (self-reported and depressive symptomology) of emotional well-being appeared consistently related to postpartum health problems (See Table 2-7). Those women reporting fatigue, headaches or nausea of moderate or major severity were 3 times more likely (9.6% vs. 33.1%) to also having poor emotional health at the time of the survey. Women with the demographics similar to those in this study tend to have poor health and worse outcomes.

The results of this study are limited to the population surveyed, though they may occur for those in higher income brackets. A weakness of this study is that although they interviewed these women several times, the results were only calculated from the interviews at 9 to 12 months. The severity of their conditions may have changed from 3 months to 9 months. It would be valuable to discussed how symptoms change over time based on the totality of data collected, but he authors chose not to in this particular cross-sectional study. This study does highlight the correlation between long-term physical complaints and the impact on depression and emotional distress. This finding alone points to a need for obstetricians, midwives, and other health professionals to acknowledge this relationship and take more time to address emotional well-being during postpartum. After childbirth, women fall out of the healthcare system into a void where physical and emotional stress and discomfort are expected, and yet they are not addressed by mainstream health care in this country. With several studies in this review of literature pointing to the same issues for most women, it is time to listen and respond with more support.

Longer Postpartum Hospitalization Options- who stays, who leaves, what changes? (2005)

This study examined the impact on a maternal and newborn health status, as well as the woman's level of satisfaction of her care, by offering a longer hospital stay for up to 60-hours after an uncomplicated vaginal delivery (Watt, Sword, & Krueger, 2005). The study took place in 5 hospitals in Ontario, Canada, based on the inquiry for potential policy change if statistically significant improvements were noted. The study stemmed from a concern of early discharge on women's and infants' health. The Ontario Mother and Infant Survey (TOMIS) was used for data collection at 2 different time intervals at the same 5 hospitals. Data collected for TOMIS I was initially collected

between November 1998 and June 1999. Data collected for TOMIS II was done between September 2001 and March 2002. Survey methods, instruments, demographics, eligibility criteria, recruitment strategy, and sample size were similar between the two surveys. Quantitative cross-sectional surveys were completed at discharge and approximately four weeks later by a telephone interview. The final sample size in each study totaled 1,250 women between the ages of 15 to 35. This sample size was large enough to substantiate the results. Surveys were available to those speaking English, French, Chinese, and Spanish.

Statistics were calculated for all variables measured, including frequency counts and percentages, or means and standard deviations. T-tests, chi-square tests or Fisher's exact tests were used as indicated to determine differences between hospital sites and the first and second surveys. Multiple logistic regression analysis was used to evaluate the influential components of being offered a 60-hour stay and for those who accepted the stay. Final results were given as adjusted odds ratio (OR) and 95% confidence intervals. The rho-squared statistic used to assess the logistic regression model had a value between 0.02 and 0.40 suggesting a good fit of the model used.

The best predictors explaining the reasons for the offer of a 60-hour stay were mostly first time mothers (43.3%), those with unmet learning needs (43.9% had one or fewer and 39.3% had 2 or more), with medical problems (49.4%), and/or the mother's own perception of her readiness for discharge (see Table 2-8). The hospital where the woman delivered remained the most important predictor of being offered a 60-hour postpartum level of service (LOS), ranging from 7.75 to 87.1% amongst the 5 sites. The next factors considered most important by the final logistic regression model were whether the mother had a family physician (OR; no-1.00, yes- 2.45) and being Canadian (1.84 OR). The women that accepted the 60-hour stay did so for the following reasons; their own health (31.7%), the health of their baby (39.8%) and breastfeeding difficulty (20.2). The major reason given by those women that declined the offer for a longer stay was that they wanted to go home (39.5%). The other reasons for declining the offer were; readiness for discharge (25.0%), dissatisfaction with hospital accommodation or care (16.0%) and having other children at home (10.2%). In some facilities, physical capacity was an issue that prevented providers from offering the longer stay. See Table 2-8 for a breakdown of the data collected in this study.

There was not a significant enough impact on the results of this study to support a policy implementation of 60-hour hospital stays for women after childbirth. However, when interviewed at 4 weeks, most women who accepted the 60-hour stay were more satisfied by their care than those who chose to go home earlier. Satisfaction of care increased with the change in policy from 74 to 89% ($p < 0.01$). Out of the women offered a 60-hour stay, 96.1% were satisfied with their level of service (LOS) even if they did not accept the extension. The results were influenced by provider's perceptions of appropriateness for a longer stay and the specific hospital's approach to postpartum care. This policy of 60-hour stay did increase the sensitivity of providers to the possible problems with shorter hospital stays. A factor significant in failing to show overall improvement with the longer stay, was the lack of change in mother's evaluation of her own health or her infant's health during the 4-week interview. Questions were asked in short closed-ended fashion with answer choices being definitely/probably yes or definitely/probably no/don't know. When women are offered the option for a longer hospital stay, they appear more satisfied and in control of their care, despite the fact that this did not appear to make a long-term difference in the initial 4 weeks after discharge. Good clinical

judgment may address this issue better than the implementation of a new policy for longer hospital stays after childbirth.

Determining the effect of an optional longer hospital stay was what this study set out to accomplish, and it was successful in its goal. However, they anticipated that the longer stay would make more of an impact on both mother's and infant's health, when in fact it did not. Although their theory was not supported, the study was strong in its findings, and the sample was a good diverse representation of the population. Assessing the needs of women after hospital discharge is subject for further research. It appears that the hospital does not offer the LOS that women really need to affect their health beyond the initial few days following childbirth. Home visits within the first few weeks after discharge can assist those who leave the hospital needing further education and assistance in building their confidence in the new skills necessary for motherhood. Other reports and surveys such as *Listening to Mothers* and the WHO guide to postpartum care give more information about care after discharge. The needs of the Canadian women in this study resemble those of women around the globe, signifying that many of the needs of women during the postpartum period may be universal.

Table 2-8. Data on 60-hour Hospital Stay
Information collected by mothers before discharge

Variables	Offered 60-hour stay Yes (%)	Offered 60-hour stay No (%)	P value	Unadjusted Odds Ratio	95% Confidence Interval
Age of mother (n=1228) 20 to 39	468 (41.7)	653 (58.3)	Not given	1.00	Not given
First live birth (n=1226) No yes	286 (40.9) 228 (43.3)	413 (59.1) 299 (5.7)	- 0.409	1.00 1.10	- (0.88,1.38)
Has family Physician (n=1226) No Yes	17 (26.6) 497 (42.8)	47 (73.4) 665 (57.2)	- 0.011	1.00 2.07	- (1.17, 3.64)
Baby without medical problems since birth (n=1229) No Yes	442 (41.1) 74 (48.4)	634 (58.9) 79 (51.6)	- 0.087	1.00 1.34	- (0.96, 1.88)
Number of concerns: 2 or more 1 or fewer	203 (39.3) 313 (43.9)	314 (60.7) 400 (56.1)	- 0.104	1.00 1.21	- (0.96, 1.52)
Mother with medical problems since birth (n=1229) No Yes	478 (41.5) 38 (49.4)	674 (58.5) 39 (50.6)	- 0.176	1.00 1.37	- (0.87, 2.18)
Mother has other children (n=1224) No Yes	219 (43.4) 293 (40.8)	286 (56.6) 426 (59.2)	0.361	1.11 1.00	(0.88, 1.40) -
Ethnic or cultural group (n=1216) Other Canadian	95 (23.6) 419 (51.5)	307 (76.4) 395 (48.5)	- < 0.001	1.00 3.42	- (2.62, 4.48)
Mother feels support at home as adequate: Other response Definitely yes	215 (39.7) 299 (44.0)	326 (60.3) 380 (56.0)	- 0.131	1.00 1.19	- (0.95, 1.50)
Readiness for discharge: *Definitely/Probably no/Don't Know *Definitely/Probably yes	65 (36.1) 450 (43.0)	115 (63.9) 597 (57.0)	- 0.085	1.00 1.33	- (0.96, 1.85)

Critical Views on Postpartum Care expressed by New Mothers (2007)

One hundred and fifty Swedish women who answered with negative responses about their postpartum care made up the sample in this study during 1999 and 2000 (Rudman & Waldenström, 2007). The purpose of this cross-sectional study was to give women a voice to express their experiences about the quality of their care during the postpartum portion of their hospital stay. Three questionnaires were given to the 3455 women that agreed to participate in the study; in early pregnancy, at 2 months postpartum, and at 1 year postpartum. Handwritten comments were completed by 1114 women, 30 of which gave both positive and negative comments. This study focused on those women that gave negative comments about postpartum care in their answers in the optional section to write down their thoughts and reflections on the last 2 questionnaires. A total of 192 women gave comments on their postpartum care experiences. After sorting through the comments for those that were specifically negative and directed at the postpartum period, a group of 150 (78%) made up the study group presented in this article. These negative statements were read through several times, coded into categories, and refined with constant comparison between the text and the codes, see table 2-9. SPSS version 15.0 was used for statistical analysis. Chi-square tests and t-tests were used to compare groups. A p value of < 0.05 was given. These women were all Swedish-native and gave birth in a large hospital that assisted in > 4000 deliveries per year, however the sample of 150 represented only a small part of the population of Swedish women.

Table 2-9. Six Categories of Negative Statements

Six Categories of Negative Statements

- Organization and environment (n=77)
- Staff attitudes and behavior (n=71)
- Breastfeeding support (n=37)
- Information (n=47)
- The role of the father (n=8)
- Attention to mother (n=91)

The complaints of these women were organized into the categories listed above in Table 2-9. Responses about the organization included things like staff shortage or lack of continuity of care, being separated from their baby, and the fathers unable to spend the night. The staff attitudes were seen as uninterested, insensitive, and rushed. Breastfeeding support was seen as insufficient and inappropriate. The information women were given was judged as insufficient, inconsistent, and incorrect. The role of the father was seen as neglected by the nursing staff. The attention given to the mother was experienced as insufficient to her physical and emotional needs. Although in Sweden postpartum care is the midwife's main responsibility, the comments were directed at midwives, nurses, doctors, assistant nurse and physiotherapists. These comments displayed an overall negative experience of postpartum care, with a cry out for more education, validation, and attention. It appears that when healthcare professionals were more task-oriented, the quality of care diminished. This study offers us constructive feedback from Swedish women pertaining to the areas of postpartum care in need of quality improvement.

Although this study evaluated Swedish women, it can serve as a guide for future research in the United States. Similar complaints are heard from American women, as seen in other studies in this review of literature. The participants of this study were of a varied background and labor outcomes, which can reveal the range of experiences. Due to the nature of this cross-sectional study, extracting the postpartum comments, does not give a full picture of each of these women's experiences through the childbearing year. While it may be easier and more economical to focus on the results of each questionnaire separately, it would be helpful in the future to review and present all the data in order to give a full picture of these Swedish women's experiences. Another weakness of the study was the lack of follow-up and inability to clarify ambiguities or discover why some women did not choose to answer the open-ended questions. A more thorough review of all questionnaires and further study of Swedish women's feelings about their postpartum care in the hospital will better guide improvements.

Quality postpartum care begins wherever the woman has given birth. The length of stay that is generally given to women giving birth in the hospital in Sweden, as well as the United States should be used to nurture and educate a woman with information, affirmation, and resources for follow-up after discharge. The high pace of our industrialized world does not excuse, though seems to contribute to insensitive and insufficient care. This is an example what Dehlot (1992) calls *institutional time*, a perception that falls short of honoring the vulnerability and slower pace more suitable for postpartum care. According to Wieggers (2006), in 1998, women began to be discharged earlier after a normal pregnancy. When women are discharged within 24 hours after delivery, a home visit was given the first day after discharge. After the first day, they received telephone contact by a midwife and a final consultation at 3 to 5 days postpartum for physical examination and PKU (phenylketonuria) of the newborn. In northern Sweden, parents can choose between early discharge and a 3-day stay in a postpartum hotel, staffed by midwives (Wieggers, 2006). While this model may sound appealing, Wieggers (2006) states that readmission to the hospital in the first month was common. This study by Rudman & Waldenström (2007) states that the common length of stay after birth was < 1 day to 5 days, but does not mention the reasons that contributed to the various lengths. They do mention the need for further research to evaluate care while at the hospital or at a hotel near the hospital. The results for this study by Rudman & Waldenström (2007), brings attention to the need for a further look at quality of care and the needs of women after childbirth in the hospital.

Alleviating Perinatal Depressive Symptoms and Stress: A Nurse-Community Health Worker Randomized Trial (2009)

This study analyzed the potential advantages in decreasing stress and depressive symptoms by using a team approach to perinatal care for low-income women in Kent, Michigan (Roman, Gardiner, Lindsay, Moore, Luo, Baer, Goddeeris, Shoemaker, Barton, Fitzgerald & Paneth, 2009). Women were randomly assigned to a group, and provided care by either the standard Community Care professional (CC) or to a Nurse and Community Health Care Worker (CHW) team-based approach. Random assignment helps to eliminate bias, when establishing two groups under comparison (Polit & Beck, 2008). The conceptual model of this study was formed by the hypothesis that the combined skills of the nurse and CHW could provide more well-rounded care and result in fewer depressive symptoms, less perceived stress, and increased levels of psychosocial resources

(self-esteem, mastery, and social support) than those cared for by usual CC. While the nurses offered their clinical skills, the CHW could provide more intensive support for relationships, social support, and practical skills using role-modeling techniques and empowerment strategies. These strategies were not described in detail in this study. Women that had a high school diploma or GED were hired as CHWs, and completed a 10 session training program, followed by monthly educational seminars on relationship building, problem solving, goal setting, stress management, and self-esteem and assertiveness.

Pregnant women that telephoned any of the five clinics in Kent, Michigan were invited to participate in this study. A total of 613 women were enrolled, randomized and followed, with 307 in the Nurse-CHW team and 306 in the CC group between January 1997 and August 2001. Permuted block randomization was conducted after the initial interview to make sure that each group had equal numbers of women with the highest needs, and then they were randomly assigned to their group. The system of permuted block randomization guarantees an appropriate distribution across the conditions studied, by randomizing the participants in blocks rather than randomizing the entire group all at once. This system is used when subjects are brought into a study over time (Polit & Beck, 2008). All questionnaires and instruments used were administered verbally. Several different scales were used to measure depression, stress, self-esteem, mastery and social support. The final sample was made up of 530 women. All women shared the same socio-demographic characteristics, parity, or need for assistance for psychosocial measures. These women ranged in age from 16 to 42 years old and were mostly single, with unplanned pregnancies. Half of these women reported a history of physical abuse (50.0% in Nurse-CHW group, 53.4% in CC group), smoking (56.4%, 63.6%), or illicit drug use (51.5%, 55.3%). Over half of them screened positive for depressive symptoms (CES-D ≥ 16), with 54.5% in the Nurse-CHW group and 58.3% in the CC group and 32% had a score linked with probable major depression (CES-D ≥ 24).

Several tools were used to analyze each woman's level of depression, mastery, perceived level of stress, self-esteem, and perception of social support. The Center for Epidemiological Studies Depression (CES-D) scale includes 20-items to assess depressive symptoms. It is a well validated measure that includes a Likert scale. A CES-D score of ≥ 16 is suggestive of a clinical level of symptoms of depression or psychological distress. The other scales used were; Cohen's 14-item Perceived Stress scale to rate participants perceived level of stress, Pearlin 7-item Sense of Mastery scale to evaluate mastery, the Rosenberg 10-item scale for self-esteem, and a Multidimensional Scale of Perceived Social Support for their perception of social support. Each of these scales has been used with pregnant women and assigned Cronbach Coefficient Alpha scores (CES-D, 0.87, Stress, 0.87; Mastery, 0.79; all others ≥ 0.85). The scales were used to create an index which had a variance of 65.3, making the Cronbach's α 0.73, which is over the cut off of 0.7 that is considered satisfactory for evaluating consistency.

Both the nurse and the CHW made the initial visit. Although not specified, it is intimated that there was one nurse and one CHW assigned to each woman throughout her care. Each Nurse-CHW team would serve approximately 50-60 families. After this visit, the nurse was required to make a minimum of 2 prenatal visits, a post delivery visit, and 2 additional visits during the postpartum year. The CHW provided support by both face-to-face contacts and via telephone. They were expected to make a face-to-face visit every other week during pregnancy, weekly in the first month postpartum, and 2 visits per month for the first 6 months postpartum. At 6 months, both the nurse and CHW

performed a reassessment of the woman's status. These services were provided through Medicaid enhanced prenatal/postnatal services, of which all participants were eligible.

Several systems of statistical analysis were used to reduce margins of error and strengthen the findings of this study. A weight was constructed from the standardized deviation of time of the observation visits to lessen the impact of any differences varying from the protocol. A mixed effects regression model created for each outcome measure following the three steps in model construction; evaluation of an appropriate random effects structure, determination of a covariance (5 x 5 matrix) R for the residual variance and the need addressing correlations in the 5 repeated outcomes and the reduction of the complexity of the mean structure of the regression model. These steps were 2-tailed (significance level $\alpha=.05$) and p-values < .05 were deemed significant.

Women in the Nurse-CHW group showed significantly less depressive symptoms (-2.4, $p=.04$), slightly less perceived stress (-3.3, $p=.06$), and higher mastery (2.9, $p=.06$) than the Community Care (CC) group, but no differences were reported for self-esteem (0.4, $p=.79$) or social support (0.8, $p=.63$). For those with low psychosocial resources, the services from the Nurse-CHW team led to a decrease in depressive symptoms (-4.0, $p=.02$) and even greater decrease in stress (-5.8, $p=.02$), but showed no differences for mastery, self-esteem, or social support. Women with high baseline stress, there was also a significant reduction in depressive symptoms (-3.8, $p=.02$). The women that had both high stress and low psychosocial resources benefited the most with a reduction of depressive symptoms (-4.6, $p=.02$). This study did support the hypothesis that a team-based approach to perinatal care for low-income women with high levels of stress and low psychosocial resources is better than the standard of care. The study was limited in that it lacked diagnostic assessments for major and minor depression and that the results are only generalizable to this particular population of women who made at least one contact with a provider before 24 weeks gestation. On the other hand, changes were seen with this high-risk population, showing the positive effects of the interventions studied. It also showed the incidence of depression and stress, and the potential effects on a woman's sense of self, which most likely will affect her parenting skills and future relationships. The CHW was able to offer more support, and was from the same community as the women in the study. This study demonstrates the benefits of home-based continuity of care through the perinatal period.

The outcomes of this study can be generalized to similar populations as it provides an example of a system of support with favorable outcomes during the postpartum period. In this study they extend the postpartum period beyond traditional definitions with good results. Further research should be geared to supporting these findings in other populations, strengthening their probable significance to all women. A possible hypothesis after reviewing this study, is that all women, regardless of their socio-economic class would benefit from home visits, especially in the postpartum period. It is possible that women of higher socio-economic category may not need home visits during their pregnancy, but that would have to be evaluated in further research. This study offers insights to the inquiry into a restructuring of postpartum care in America.

Emergency Department Use During the Postpartum Period: Implications for Current Management of the Puerperium (2010)

The purpose of this study was to define the patterns of postpartum morbidity of women in the United States, who visited the emergency department for emergent and non-emergent care during 42 and 100 days postpartum during 2007 and 2008 (Clark, Belfort, Dildy, Englebright, Meints, Meyers, Frye & Perlin, 2010). The data was collected from The Hospital Corporation of America, where approximately 220,000 deliveries occur annually in 21 states. Initially, the authors examined diagnostic codes and descriptions of emergency department visits in the first 42 days after hospital discharge. The second analysis examined the temporal pattern of those discharged home and the number of inpatient hospital admissions from the emergency department or another hospital within the 100 days after delivery discharge for approximately one-half million women who delivered between 2007 and 2008. They used previously collected hospital data for billing and other quality control uses that were de-identified for this quality improvement project. A chi-square test using the Yates continuity correction was used for statistical analysis. This was the only statistical analysis listed in this study report.

In the year 2007, 222,084 women delivered in a Hospital Corporation of America facility with the United States. Of these women, 140,377 (63.2%) were vaginal births and 81,707 (36.8%) were cesarean deliveries. From this cohort of women, there were 10,751 emergency departments visits within 42 days of being discharged after delivery. Five thousand, six hundred and seventy-three were vaginal births (52.8%) and the other 5078 (47.2%) were cesarean deliveries. Results from this study revealed 25% of visits in the first 42 days occurred in the first four days, 50% in the first 10 days, and 75% within the first 24 days after initial hospital discharge. Refer to Table 2-10 and 2-11 for the lists and percentages of non-emergent and emergent reasons for emergency department visits. It appears that 1 out of 20 (5%) women who give birth in the United States will go to the emergency room before their 6-week postpartum visit.

Table 2-10. Top 5 non-emergent reasons for postpartum pregnancy related emergency department visits

Condition	After vaginal birth per 1000, n (%)	After cesarean birth per 1000, n (%)	Total pts presenting, n	Postpartum women with condition per 1000 births, %	P value	Odds ratio, Confidence interval
Urinary tract infection	521 (3.7)	344 (4.2)	865	6.2	.074	0.990-1.301
Abdominal pain, unspecified	265 (1.9)	404 (5.0)	669	4.8	.000	1.173-1.522
HTN/Preeclampsia	193 (1.4)	225 (2.3)	418	3.0	.000	1.655-2.431
Endometritis	217 (1.6)	187 (2.3)	404	2.9	.000	1.219-1.801
Mastitis	279 (2.0)	118 (1.4)	397	2.8	.004	0.586-0.900

Table 2-11. Top 5 emergent reasons for postpartum pregnancy related emergency department visits

Condition	After vaginal birth per 1000, n (%)	After cesarean birth per 1000, n (%)	Total pts presenting, n	Postpartum women with condition per 1000 births, %	P value	Odds ratio, confidence interval
Postpartum hemorrhage	474 (3.4)	189 (2.3)	663	3.0	.000	0.578-0.810
Wound infection/ disruption	0	482 (5.9)	482	2.2	.000	216.849-∞
Other surgical complications	7 (<0.1)	253 (5.0)	260	1.2	.000	29.884-129.818
Lumbar puncture headache	173 (1.2)	80 (1.0)	253	1.1	.101	0.610-1.035
Psychiatric condition or drug abuse	157 (1.1)	95 (1.2)	252	1.1	.815	0.806-1.341

This study provides data to support the conclusion that the current U.S. system of scheduled office visits and education during the postpartum period are inadequate at preventing postpartum morbidity. Out of all of the emergency visits, 58% of them involved morbidity related to pregnancy. The authors estimated that two-thirds of these conditions (see Tables 2-10 and 2-11) could be managed in an outpatient office setting or prevented altogether. The authors mention that previous publications have determined the demographic and geographic diversity as a good representation of the entire country. This study, however, does not give any demographics of the women on whom this data was compiled and evaluated. They also mention that looking at the categories of morbidity suggests that many women in the population of this study did not have access to primary health care, which makes it unlikely that this is a representation of the entire nation. Although out-of-hospital births make up 1% of births in the United States, according to MacDorman Menacker & Declercq (2010), not including the statistics on how often this part of the population visits the Emergency Department also makes this an incomplete representation of the entire country. Without knowledge of the demographics of the population studied, we cannot generalize this data to any particular part of the population, however we can use it guide further research into alleviating postpartum morbidity with an increase of care in the first few weeks after childbirth, and especially before 6 weeks.

Knowing that the peak of postpartum morbidity occurs in the first ten days, it would make sense to make the initial postpartum follow-up appointment during this time, preferably in a woman's home. There is little clinical relevance to support the existing system of one postpartum visit at six weeks, one month beyond the most crucial time of the greatest postpartum morbidity. This study highlights the fact that many people lack access to primary health care and other healthcare professionals, such as lactation consultants. With access to a primary health care provider, some of the issues for which these women sought care in the emergency department, may have been handled in the office or through a home visit, cutting costs and promoting preventive practices. The

cost of emergency room visits compared to that of preventative and in-office treatment is expensive, and a good reason for further research.

Key points made by this study strongly support this inquiry into restructuring the current healthcare system to improve the health and well-being of women and their children. This study suggests that changes be made within the current system to include a thorough standardized approach to post-discharge evaluation and education for all postpartum women, establishment of a medical and dental primary care relationship for every woman, and ≥ 1 visit within the first 2 weeks after discharge. The current system does not contribute to early detection of common postpartum problems as suggested by these authors and the WHO (1998), or adequately support women during the period of peak morbidity in the weeks following childbirth. This study did a good job at pointing to the weaknesses of the current American postpartum health care system by looking at the extent that women visit the emergency department for postpartum problems.

Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice (2007)

Seven hundred and fifty-five women participated in this cross-sectional study in Albuquerque, New Mexico, designed to address the prevalence of postpartum depression (PPD) at 6 weeks postpartum, the benefits and challenges to using a PPD screening tool in a busy obstetric practice, and the demographic and clinical characteristics related to a positive screen of PPD using the Postpartum Depression Screening Scale (PDSS) (Mancini, Carlson & Albers, 2007). A prevalence study is a cross-sectional study used to estimate the proportion of a population with a certain condition at a given point of time (Polit & Beck, 2008). The prevalence of PPD in developed nations ranges from 5% to 25% (Mancini et al, 2007). The Postpartum Depression Screening Scale (PDSS), developed by Beck and Gable, is a 35-item Likert-type instrument created for new mothers. It is thought to be easy to use because the questions are formed using women's own words (Mancini et al, 2007). The women in this study have similar demographics and were mostly Hispanic or Non-Hispanic white. The high-volume obstetric practice that conducted this study included 11 obstetricians and 9 nurse-midwives. At the 6-week postpartum visit, medical assistants explained and distributed the PDSS to women who agreed to participate in the study and complete the questionnaire. Those with potential symptoms of PPD were encouraged to increase their sleep, support, and nutrition, and contact the healthcare provider if their symptoms worsened. Those with a positive screen were referred to a mental health professional. Evaluations of this particular scale showed a PDSS score of ≤ 80 has a sensitivity of 94% and specificity of 98%.

Sixteen percent of the women positively screened for PPD, with another 20% having symptoms of potential risk. This study affirmed results of others in that 1 out of 6 new mothers will have significant symptoms of concern. Two variables that were statistically significant for the occurrence of PPD were those who had a history of depression and those who were exclusively bottle feeding. Most of the study participants who screened positive for PPD using the PDSS, had less than a high school education (n=87, 12%), were unpartnered (n=196, 26%), exclusively bottle feeding (n=235, 31%), and had a history of depression (n=159, 21%), all with p value of $< .01$. Teenagers were more likely to test positive than women over 20 years old (n=19, 21%). Many of the providers in the practice were uncomfortable with psychiatric issues and felt inadequate at addressing

them. The medical assistants were essential to the success of screening women in this busy practice, as they explained the scale and totaled the score. A network developed between the obstetricians and midwives in the practice and community mental health clinicians that continued beyond the study. A success of this study demonstrated the possibility of and the need for integrating such a PPD screen into a busy obstetric practice, as well as a team-based approach to health care.

The authors bring awareness to the importance of screening for postpartum depression. Their study demonstrates the potential correlation between breastfeeding positively affecting a woman's emotional state and possibly decreasing the incidence of PPD, but more research is needed to confirm these findings. This study suggests the importance of including psychological evaluation, at least by screening for PPD amongst the focus of gynecological screening and choices for contraception typical to the 6-week postpartum follow-up appointment. By the time a provider sees a woman postpartum at 6 weeks, they may have missed the critical time when the onset of PPD is most likely to occur and may have been prevented or appropriately treated earlier. Some women may have discontinued breastfeeding because of symptoms of PPD, which could have greatly affected their bonding with her baby and the integration into the role of being a mother. Discontinuing breastfeeding before 6 weeks may have contributed to the results of this study. Educating women about the signs and symptoms of PPD should be an essential part of prenatal care in all settings and early postpartum education given to women before being discharged from a hospital or birth center.

Global and relationship-specific perceptions of support and the development of postpartum depressive symptomatology (2007)

Exploring perceptions of support and its influence on postpartum depressive symptomatology was the focus of this study conducted in Vancouver, British Columbia, Canada, from April 2001 to January 2002 (Dennis & Letourneau, 2007). The authors explored whether women discriminated between global and relationship-specific perceptions of support and the influence of these two on depressive symptomatology in the immediate postpartum period. According to Dennis & Letourneau (2007) global perceptions of support refer to "...a stable view held by an individual about the general positivity or negativity of the social world" (p. 390). This global perception reflects a person's feeling of acceptance by others and the belief that others will be available to help them in difficult times (Dennis & Letourneau, 2007). On the other hand, relationship-specific perceptions of support refers to a person's past experiences with specific individuals (partner, mother, women with children) and less about a their general outlook on social life. Relationship-specific perceptions reflect one's experiences of support received from family and friends (Dennis & Letourneau, 2007). The purpose of this study was to determine if women differentiated between each of these perceptions of support, to examine the influences of each in the immediate postpartum period, and its effect on the development of postpartum depressive symptomatology at 8 weeks after childbirth.

This evaluation took place through postal questionnaires at 1 week and 8 weeks postpartum. Women more than 32 weeks pregnant were recruited during their pregnancy by family physicians, obstetricians, and midwifery offices. Public health nurses recruited other women during a phone call offered to all mothers 48 hours after discharge. In total, 594 women completed and returned the 1-week postpartum questionnaire (71% response rate) and 498 (84%) returned the 8-week questionnaire. There were no baseline differences noted between the women who were recruited

antenatally versus postnatally and those who completed the 8-week questionnaire compared to those who did not. This high response rate, with minimal nonresponse bias support this study's statistical construction validity and indicates an ability to generalize these findings to the population (Polit & Beck, 2008). The authors used a formula presented by Tabachnick and Fidell used to calculate a proposed sample size that would increase the validity of this study. It was found to have a Type I error of 0.05 and a Type II error of 0.02, showing the sample size (N) needed to evaluate independent predictors (m) for the multivariate analysis, which was : $N= 50 + 8 m$. With 25 potential independent predictors in this study, the minimum sample size required was 304. The women in this study ranged from 18 to 44 years old. They were mostly Caucasian (91%), and married or living in common-law (90%). Their education achievements varied with 39% having a high school diploma or less, 38% with a college diploma, and 21% with a university degree or higher. Forty percent of the women had incomes less than \$24,000, 26% earned between \$24,000 to \$37,000, and 34% had incomes higher than \$37,000. Of all the women, 40% were primiparous, 74% delivered vaginally, and 69% were discharged for home within 48 hours after delivery. Three scales were used to collect the data, and assess the symptoms and perceptions of this group of women.

The Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report instrument was used in the assessment of depressive symptomatology. The EPDS has been used in many studies with well documented reliability and validity. Final scores were achieved by rating each item on a 4-point scale to produce a total score ranging from 0 to 30, the higher of which is indicative of lower maternal mood. With a cutoff of 12/13 at 6 weeks postpartum, this scale has a sensitivity of 69% to 95% and a specificity ranging from 78% to 96%, when compared with the diagnosis of PPD given after a psychiatric interview.

The Social Provisions Scale (SPS), a 24-item self-report was used to assess the global perceptions of support at 1-week postpartum. This scale is based on the theoretical work of Robert Weiss in 1974 (Dennis & Letourneau, 2007). In this work, Weiss describes "...six different social functions or "provisions" which are obtained from relationships and are needed for individuals to feel adequately supported," but some provisions are more critical in certain circumstances and in different phases of life. These six provisions included in this scale are; guidance, reliable alliance, reassurance of worth, attachment, social integration, and opportunity for nurturance (Dennis & Letourneau, 2007). A 4-point scale was used to generate a score ranging from 24 to 96. The higher scores indicate higher levels of global support. Each of the six provisions was scored with subscales and total scores ranging from 4 to 16. This scale has been used with postpartum women, and shown to have well established reliability and validity, including factor structure. Factor analysis is used to organize complex interrelationships among items in a scale, in order to identify those that come together into one unifying concept (Polit & Beck, 2008). The third scale was used to collect data about relationship-specific perceptions.

The Social Provisions Checklist (SPC), a 30-item self-report was used at 1-week to assess relationship-specific perceptions of support. This scale is also based on the work of Weiss (1974) using the 6 provisions, each with 5 items. The participants were asked to respond to each of the 30 items on the SPC three times in reference to their partner, mother, and other women with children. A 5-point scale was used to produce a total score for each relationship ranging from 30 to 120, with the higher score indicative of higher levels of support. Separate scores were also tallied for each of the 6

provisions using a range of 5 to 20 points. Because the SPC had not been used for a postpartum population before, it does not have the established reliability and validity, unlike the SPS.

A computer program called Statistical Package for the Social Sciences (SPSS), commonly used to calculate data, and a two-tailed significance level of 0.05 was used for data analysis for this study. Descriptive data was calculated using means, frequencies, and percentages. The association between categorical data was analyzed using Pearson χ^2 analyses, a correlation coefficient illustrating the degree of relationship between two variables. One-way analysis of variance was used to determine the differences amongst the ordinal variables and independent two-sample *t*-tests were used to examine continuous variables. Cronbach's α coefficients were calculated for each global and relationship-specific domain and to differentiate between these measurements, principal components factor analysis with orthogonal rotation was used. The impact of relationship-specific support on global support was examined by the use of multiple regression, with significant variables retained if the *P*-value for the beta-estimate was 0.05. These systems and measurements are often used when studying and comparing relationships, confirming validity or the accuracy of any conclusions drawn from the collected data.

The first objective in this study was to look at the discrimination made by women between global and relationship-specific support measures. The three domains evaluated from which this support might be generated were a woman's partner, mother, or other women with children. The results showed that women do make clear distinctions between global and relationship-specific support. See Table 2-12 for correlations between the total scores. The standard multiple regression was performed to directly look at the relationship between these two perceptions of support. Relationship-specific provision subscales for all three domains (partner, mother, women with children) were used. In looking at global support, a moderate portion of variation was accounted for by the relationship-specific measures ($R^2 = 0.37$). The four variables that were statistically influential in global support were; attachment to partner ($\beta = .023$, $P = 0.004$), reassurance of worth from mother ($\beta = 0.22$, $P = 0.01$), attachment to other women with children ($\beta = 0.25$, $P = 0.007$), and social integration with other women with children ($\beta = 0.19$, $P = 0.01$). Support from the partner and women with other children were positively correlated with global support, but the strength was moderate.

The second objective of this study was to predict depressive symptomatology, and this was based on the EPDS scores at 8 weeks. At 8 weeks, the prevalence of depressive symptomatology was 8% ($n=38$), with the overall EPDS score of 5.5. Although this does not show a large incidence of PPD, women with lower incomes and perceptions of global support were found to have more depressive symptomatology at 8 weeks postpartum ($F=9.01$, $P=0.003$). According to Dennis & Letourneau (2007), these findings among low-income women are consistent with other literature, but they did not cite these other studies. There was no data gathered on the rate of depressive symptoms present antenatally among the participants as a confounding variable, which may have contributed to the results. What this study does illuminate is the need for a woman to feel supported, in particular by her partner. This was a complex study, which sought to reveal what type of support women feel to be the most helpful and meaningful based on the perceptual differences between global and relationship-specific support, and the effects of these on the development of postpartum depression at 8 weeks.

Raising questions about what constitutes effective preparation for the postpartum period is important for future research. Additionally, looking into the effects of organized postpartum systems, as seen in other countries and with those who plan for family or hired assistance, on maternal perceptions of relationship-specific or global support and postpartum depression may be valuable. The idea of increased support positively affecting outcomes of maternal and infant health is the foundation of this inquiry, and demonstrated by this study. This study differentiated between global and relationship-specific care, but was unable to verify a strong difference between the two. Although the authors did not find a strong difference between these perceptions of support, it is worth acknowledging the value of the conceptualization and measuring of these phenomena. Previous literature found in this review, provides examples of effective support offered by professionals outside of the family, such as the role of the MCA in the Netherlands’s system and comparison of support systems offered by the Nurse-CHW team or Community Care (CC). The complexity of comparing the support offered by friends and family with that of other professionals has been demonstrated by this study, but is worth further exploration. Despite certain weaknesses in this study, the importance of support was demonstrated by the data collected, and offers positive insight into the need for support postpartum. Future studies about the effect of postpartum support on the incidence of PPD are warranted. The bottom line is that women need support, and that feeling supported is essential to their emotional well-being.

Table 2-12. Correlations between total scores on global and relationship-specific subscales (Replicated from this study by Dennis & Letourneau 2007). All correlations are significant at the level of 0.01 (2-tailed)

	Global	Partner	Mother	Women with children
Global	-	0.47	0.31	0.47
Partner	-	-	0.21	0.26
Mother	-	-	-	0.27

Exploring Chinese Women’s Cultural Beliefs and Behaviours Regarding the Practice of “Doing the Month” (2004)

“Doing the month” is the title given to the food choices, specific restrictions, and various practices observed by the Chinese culture during the 30 days, following the first 12 days, after childbirth. The purpose of this study was to explore the current participation in and cultural beliefs of these postpartum customs by modern Chinese women living in Hong Kong (Holroyd, Twinn, & Yim, 2004). This article is the postpartum section of a larger longitudinal study that investigated the effectiveness of childbirth preparation class in preparing women for childbirth. The data that focused on “doing the month” was retrieved through telephone interviews.

The sample consisted of women that enrolled in a series of 4 childbirth preparation classes from two different hospitals. A total of 44 completed the telephone interviews (response rate of 40%). A second group of women enrolled in other childbirth classes were also invited to participate. Of the

212 invited from the second group, 100 completed the interviews, making the final sample size 144 women, ranging from 31 to 35 year old. All of the women were married, with a household median income of \$30,000-\$40,000/month, which is higher than the median monthly income of employed people in Hong Kong. This study sample is made up of an older and wealthier cohort of the Hong Kong Chinese women. Data collected from the interviews were analyzed by content analysis and generated into categories by two researchers. All of the women interviewed knew the practice of “doing the month” and initiated at least some aspects of the known practices. The categories developed by the content analysis for the range of issues found in this study, are listed in Table 2-13.

In Chinese medicine, qualities and classifications of hot and cold are used when describing food, internal and external temperature, physical conditions, and the environment. Some women ($n=70$) knew that bathing and hair washing was avoided during “doing the month,” because it is thought to let in wind that could affect their future health. While some women ($n=59$) avoided bathing in accordance with age-old practices, some ($n=72$) waited until after 12 days and then bathed with warm water or ginger infused warm water. The lochia, blood and discharge that occurs after childbirth as the uterus and placental attachment site heals, is considered dirty blood and so most herbs and foods that are meant to build and move the blood are avoided until after the twelfth day postpartum. All women honored this rule. Most women ($n=62$) drank or cooked with Chinese wine, and believed it would expel stale blood and get rid of flatus. The women interviewed shared similar food choices and recipes. This included chicken soup, fish soup, deer antlers cooked in chicken wine, various dishes made with ginger, dates, and ginger wine made with pig trotters (pig feet). Chicken soup or fish soup was eaten regularly by less half of then women ($n=43$). These foods are thought to be a tonic or remedy to restore the balance of the good blood in the body. A small portion of the sample ($n=19$) confessed to honoring these practices mostly because of pressure and superstitions of bad health and misfortune told to them by their mothers. They all believed in the care, but influenced by modern culture, may not have adhered to the practices with the strictness of their ancestors. The conveniences of warm running water and a more stable economic status may have influenced a more modern application of “doing the month” (Holroyd et al, 2004). Further research is needed to explore the practices of Chinese women today both in their countries of origin and the United States.

Exploring the current usage of such ancient practices would make an interesting study. This study discussed how modern life and newfound independence for women may influence a woman in maintaining, modifying or dropping the customs of their heritage. Many of their food choices and medicines, such as deer antlers may not be used as much in the United States. The article of this study was poorly written, though it provided interesting insights into the Chinese system of postpartum care. Another weakness of this study was that it failed to inquire about the effects experienced by the women in the study. More attention was placed on identifying the practices, and a discussion of possible modern influences to the abandonment of traditions. The authors spoke of some of the changes noticed with modernization and the increasing independence of women, making them more self-assured and possibly less likely to follow their parents or mother-in-law’s advice. While some women may stray from traditional practices, many in women in this study also feared the effects of not adhering to such protective practice in the initial postpartum period. The concepts of hot and cold are found in many cultures around the world, and may be useful if applied with a more modern approach (Eberhard-Gran et al, 2010). It is hard to imagine the medical system adopting such principles that do not have association with modern science, but nonetheless it is important to acknowledge and honor in patients that may continue to adhere to such practices. It is interesting to

note that the thirty days of “doing the month” in addition to the first twelve days after childbirth equals 42 days, similar to the 42 days honored in most cultures and the 6-week postpartum visit in the United States.

Table 2-13. Categories of Postpartum Issues and Practices

Food Avoidances	Wind and Water Prohibitions	Breastfeeding Proscriptions and Prohibitions	Cultural Imperative of Timing	Contemporary Autonomy of Chinese Women versus Conforming to Female Centered Kinship Expectations
<ul style="list-style-type: none"> • Avoid hot food • Avoid raw food • Avoid cold food • Eat Restorative foods: Chinese wine, ginger vinegar with pig feet, chicken soup, red dates, longan tea, chicken wine, deer antlers. • Expelling the heat of childbirth • Tonics & remedies to restore balance 	<ul style="list-style-type: none"> • Avoid hair washing and bathing for 1 month • Boiled ginger water for bathing or shampooing • Warming food and boiled ginger water used to expel “wind form the head” • Prevent cold from entering the body 	<ul style="list-style-type: none"> • Avoid: hot and spicy foods, chicken wine, fish soup, papaya soup. • Examples of other food to promote milk supply were not given in this study. 	<ul style="list-style-type: none"> • “Doing the month” • Beginning remedies after the first 12 days, when the lochia (“bad blood”) clears • Linked to astrology and fertility cycles • Women excused from usual obligations promotes optimal state to care for her baby and heal her body • Stop taking tonics after 30 days 	<ul style="list-style-type: none"> • Adhering to tradition because of pressure from mother • Afraid of consequences of not following • Importance of family support helping first time mothers cope • Some middle class (<i>n</i> =31) employed a maid helping to ability for “doing the month”

Final Statement

As a culture develops by the influences of those within it, so will the improvements to the current American system require an evolutionary redirection by the public, policy makers, insurance companies and those within the medical system. The review of literature presented here and explored within the conceptual framework supports a much needed overhaul to the current healthcare system for postpartum women and their families in the United States. It is time to listen to what mothers have shared in order to make the changes that will meet their needs, as well as the needs of their infants and families. Concerns for women among various research teams, disciplinary perspectives, and organizations such as The World Health Organization and Maternity Center Association has led to proposals for improving the postpartum health care system in the United States and abroad. The vulnerability and importance of adequate care for women and infants during the initial 42 days after childbirth is well documented in this review of literature. The questions still remains as to what constitutes adequate care, and how can we create a system that meets the needs of American women. Along with recreating the framework for a new system, reconceptualizing our vision of postpartum care and the needs of mothers is a fundamental part of this process of change.

Research suggests that more than a 6-week visit is needed to screen women for postpartum depression, and assist them with other common challenges during this time; such as breastfeeding, mastitis, exhaustion, perineal discomfort or infection, and more (Declercq et al, 2002). Postpartum depression is estimated to affect 5% to 25% of all mothers (Mancini wet al, 2007). More research is needed to address what constitutes an effective system of care to reduce this negative outcome. The WHO (1998) advises that changes be made to increase a woman's access to care. One proposal for this restructuring would be to offer women a home visit in the first week after birth, a second visit in-home or in their provider's office at 2 to 3 weeks, and a final visit with their provider at 6 weeks. More care could be offered depending on the needs of each individual woman. Using professionals such as postpartum doulas, nurses, lactation consultants, midwives, or those trained like the MCA in the Netherlands would provide more employment for women in America, as well as, a good use of available resources. Support groups for women teaching about breastfeeding, parenting, wellness and nutrition, or counseling might greatly enhance a woman's well-being and eliminate any feelings of isolation. The use of postpartum support groups should be studied in the future. Using the financial resources and outreach of organizations such as the March of Dimes, Childbirth Connection, Maternity Care Coalition, American College of Nurse-Midwives and other professional organizations will be valuable in the implementation of a new and improved system, including community-based programs for new mothers.

A woman's life is greatly affected by her experiences of pregnancy, childbirth, and the postpartum period. Adequate postpartum care may prevent women from long-term suffering related to conditions that developed after childbirth. However, the full impact on their future health and well-being and that of their families is unknown and must be studied over time. The traditional practices and models of care found in other countries, such as the Netherlands, Bali, China, and India, provide inspiration and direction needed in this era of health care reform. The studies and proposals for

change presented here support the recognition of the problems within the current system in the United States, and suggest the need for remodeling. Women and children are the foundation of humanity, and deserve the attention and services necessary for their health and happiness.

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