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EXECUTIVE INDEX

Early postnatal discharge: What the mothers say

The first New South Wales early postnatal discharge program for mothers leaving the institution where they had given birth was begun from Westmead Hospital in 1983. This program of Early Postnatal Discharge (EPD) was formalised after mothers expressed their desire for increased "domesticity in reproduction". It was designed for mothers leaving the hospital within 72 hours of giving birth who would be attended at home by daily visits of a midwife until the seventh postnatal day. The influential report on maternity services published by the Ministerial Task Force on Obstetric Services in New South Wales (1989),[2] commonly referred to as the Shearman Report, suggested that the practice of EPD would have a dramatic effect on hospital maternity bed requirements and would cancel out projected bed deficits. Thus the wishes of mothers combined with the power of institutions to offer a program to mothers, has become increasingly popular.

In New South Wales about one third of postnatal mothers currently choose to take EPD with some institutions aiming to have half of their postnatal women home within 48 hours of delivery. As the length of a standard postnatal hospital stay has shortened from 6.22 days in 1989,[2] to 3.8 days in 1996,[3] so too has the maximum period mothers may stay in hospital and still qualify for an EPD program. Commonly mothers are now required to leave the institution within 48 hours of giving birth rather than the three days that had been the qualifying period.

Early postnatal discharge is itself not a new concept. Its first recorded use was in New Orleans, 1942, when well postnatal mothers were discharged home soon after birthing to relieve pressure on crowded hospital situations.4 Since then, its effects on mothers and babies have been widely studied but the research has primarily focused on the safety to mothers and babies of going home early. Lock's (1999)[5] study took as its focus the experience of mothers who elected early discharge. The women who participated in that study, a mixed group of first, second and third time mothers, had chosen to take early discharge before they went into hospital. The project tracked their experience from this decision, through their coming home experience into a reflective evaluation of the experience made about six weeks after coming home.

Each of the women in the study was positive about coming home early. The reasons they gave for leaving included:

- an eagerness to return quickly to their families,
- wanting to make their own way into mothering their baby,
- feeling physically uncomfortable in the hospital, and
- feeling as if they would get more help, and more rest, at home.

There was an apparent sense of psychological discomfort expressed by the mothers about being in hospital. The rules of the institution were not those made by the mothers and they didn't know when they

might be breaking these rules. Being a patient in hospital also exerted its influence with one woman stating that the longer she stayed in hospital the sicker she became and she had to go home to avoid the creeping and increasing dependence she felt.There was also a concern that being in hospital lacked a sense of reality that was an important basis to mothering the baby.

Home was where these mothers felt they belonged. It was at home that they were able to come to know their babies. It was only at home that the parenting of the child could be shared with the father as wanted by the couples. Being at home meant being in a familiar place that was comfortable and in which the mothers felt they had some control over their environment. The physical ease of home combined with a freedom in decision-making about infant care that built a spiralling sense of comfort and confidence.

As a result of this study, I am in no doubt that mothers who leave hospital early adapt to their new roles more easily but I am also convinced of the crucial role of support at home. The mothers in this study were not all well supported. From the experience of those who were supported, it was apparent that the gender of the support person was not important. Even though physical acts of domestic assistance were gladly accepted, these were not as important to the women as praise and affirmation of their ability to mother. They need lots of it.

Because this study followed the mothers through their early discharge experience, it resulted in a deeper understanding of the sort of midwifery care that was appreciated by the mothers and of the differences in care given them by the midwives at home. The descriptions of care interactions with the midwives in hospital present a picture of fragmented, task-oriented care that maintains a hierarchical structure with the mother at the bottom. In comparison, care offered to mothers at home appeared to be more collegial. The midwife came and stayed until the care interaction came to its logical conclusion. The mothers felt as if the midwife didn't have to *"rush off to do someone else"*. It was a style of care that the mothers thought was *"heaps better"*. A style that provided formal support offering to the mothers a feeling of security. It was a crucial *"backup thing"*. The home-visiting midwife importantly functioned to form a bridge between the mother and the health care services available to the mother in the community.

It is my belief that if we are committed to the care of postnatal mothers we will maintain the option of going home early but it must be with support. While early discharge midwives can give that support they can also assist by guiding informal support persons into behaviours that are known to be most beneficial to new mothers.

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Women's health in the first 6 months after birth

Much of the focus in early childhood and community settings is on the health of the infant. While this is clearly important, the physical, emotional and social needs of the mother must not be overlooked. This paper will briefly describe some of the common physical problems and social stresses experienced in the first six months after birth. Whilst recognising that some of the issues highlighted in this paper are often discussed in relation to postnatal distress and depression, this paper does not attempt to provide a comprehensive coverage of those aspects of women's health in the first six months. There are many materials available that specifically address postnatal distress and depression.

Major maternal morbidity (postpartum hemorrhage, eclampsia) is well described in obstetric and midwifery textbooks.[1] Fortunately these conditions are rare and should be treated as medical emergencies in hospitals. Women report a number of other health problems, which are often seen as less important (or less life threatening) and have therefore received little attention. Nevertheless, these problems are uncomfortable and impact on the way women cope with their day-to-day life and their relationships with others.

A population-based survey in Victoria found that 94% of women had one or more health problems in the six months after childbirth.[1] The most common health problems were:

- tiredness (69%),
- backache (44%),
- sexual problems (26%),
- haemorrhoids (25%), and
- perineal pain (21%).

Another population based survey in the Australian Capital Territory also identified tiredness as the most common health problem in the first six months.[2] Events during labour and birth can impact on the health of women in the postnatal period. Backache has been associated with the use of epidural anaesthesia.[3] Women who have assisted vaginal births (either by vacuum extraction or forceps) seem more likely to report bowel problems, urinary incontinence, sexual problems and perineal pain compared with women who have normal births.[1,2]

Some women may feel embarrassed about their health problems and may find it difficult to discuss such topics as a painful perineum, sexual problems or urinary incontinence. In addition, a focus on the baby may mean that the woman's issues are not always addressed adequately.

Social stresses also impact on the emotional health of new mothers. Women often start motherhood with limited preparation and few role models to follow.[4] Women may also be socially isolated and uncertain of how to develop links with other women in their community.[5] Intellectual isolation and a loss of professional identity have also been reported, particularly for women who worked outside the home prior to the birth of their baby.[4] The relationship the woman has with her partner also changes with the birth of a baby, whether it is the first or subsequent child. Women have less time for themselves and to spend with their partner.[4,6] Perineal pain and sexual problems are also common in the first six months, which can alter the physical relationship of the couple.

Many of the strategies to help women during this time involve listening and spending time with women. Inviting women to discuss their health problems may help them to identify possible solutions. This invitation may also help women feel that their problems are worthy of discussion.[1] It is important to ensure privacy and confidentiality for consultations as this may help women to discuss sensitive or embarrassing issues. Disregarding problems as 'common' or 'expected' will not help women talk about their health or encourage them to discuss other issues in the future. What might be 'expected' and 'common' to a health professional may not appear so to a woman. Identifying the type of labour and birth may help explain some of the physical problems and direct appropriate referral. Physical problems, however minor, can be debilitating and cause distress and unhappiness. Clinicians must ensure that they are familiar with the most effective management of

common problems and the services that are available in the community.

Linking women in with their community is an important strategy to help develop social networks and support. New mothers' groups can help women to develop a social network. Unfortunately, many 'new mothers' groups' are aimed at women after their first baby and those with their second or subsequent baby can miss out. Postnatal support groups that involve all women may help facilitate a social network and may help reduce isolation for all new mothers.[7]

In summary, it is important to acknowledge the health needs of the mother as well as the infant. Healthy women will probably be happier mothers and be more able to take on the multitude of roles and responsibilities that parenthood brings.

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