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POSTPARTUM WOMEN'S PERCEPTION OF EARLY DISCHARGE FROM HOSPITAL

BY

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the degree of Master of Science in Nursing (Midwifery)

SUPERVISOR: DR P. MCINERNEY

Johannesburg, March 1999

DECLARATION

I, Ogar Rapinyana, declare that this research report is my own work. It is being submitted for the degree of Master of Science (Nursing) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.



OGAR RAPINYANA

02. 09. 99

DATE

DEDICATION

This work is dedicated to the following:

* My husband, Simon Oakantse Rapinyana, who tirelessly endured the inconveniences of a schooling wife. Thank you for your continuous support and encouragement.

* My two sons, Kabelo and Mpho, for their invaluable patience, support and understanding.

* Lastly and not the least, my late mother.

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I wish to thank all those who helped me in accomplishing this task:

* My supervisor, Dr P. McInerney, for her patience, support and guidance.

* My co-supervisor, Mrs B. Lester, for her motivation and encouragement.

* My typist, Beverley Nobel for diligently typing this project.

* Special thanks are extended to my statistician, Temba, who assisted me in data analysis.

* Lastly, but not the least, the Botswana Government/Ministry of Health.

ABSTRACT

The purpose of the study was to investigate womens' perceptions of early discharge after childbirth and to determine their needs. The study aims to create an awareness that could lead to improved service and meet the needs of postnatal women. The study was conducted in Francistown, Botswana. A descriptive survey design was used in order to study the views of postpartum mothers in relation to early postpartum discharge. The target population was postnatal mothers six weeks post-delivery. Simple random sampling was used to select five clinics for the study. Convenience sampling was used to select a sample of at least 22 postnatal women from each clinic. A sample of 110 postnatal women was obtained from five clinics. A structured interview schedule was used and both open and close-ended questions were utilised. The findings of the study revealed that respondents felt that it was good to be discharged early in order to join their families at home for support. Those respondents who felt it was not good, felt that they lacked information and basic skills in relation to care of their babies and self. The findings further showed that primiparae experienced stressful events post-delivery for example, tearfulness. The limitations are that the study was conducted in only one urban setting, therefore the findings cannot be generalised beyond the sample. The findings of this research are also limited to the five clinics. It is recommended that each postnatal ward should have a teaching manual which provides instruction or information that must be given by the midwives to the postnatal women. It is also recommended that the needs of the mothers be recognised, so that information given is individualised. The researcher

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The purpose of the study was to investigate womens' perceptions of early discharge after childbirth and to determine their needs. The study aims to create an awareness that could lead to improved service and meet the needs of postnatal women. The study was conducted in Francistown, Botswana. A descriptive survey design was used in order to study the views of postpartum mothers in relation to early postpartum discharge. The target population was postnatal mothers six weeks post-delivery. Simple random sampling was used to select five clinics for the study. Convenience sampling was used to select a sample of at least 22 postnatal women from each clinic. A sample of 110 postnatal women was obtained from five clinics. A structured interview schedule was used and both open and close-ended questions were utilised. The findings of the study revealed that respondents felt that it was good to be discharged early in order to join their families at home for support. Those respondents who felt it was not good, felt that they lacked information and basic skills in relation to care of their babies and self. The findings further showed that primiparae experienced stressful events post-delivery for example, tearfulness. The limitations are that the study was conducted in only one urban setting, therefore the findings cannot be generalised beyond the sample. The findings of this research are also limited to the five clinics. It is recommended that each postnatal ward should have a teaching manual which provides instruction or information that must be given by the midwives to the postnatal women. It is also recommended that the needs of the mothers be recognised, so that information given is individualised. The researcher

goes on to recommend that a similar study should be conducted on teenage mothers to identify problems of groups with special needs.

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CHAPTER 1

1.1 INTRODUCTION

Since the declaration of the Alma Ata in 1978, increased emphasis has been placed on community participation and Primary Health Care (PHC) as the key strategies for the attainment of health for all by the year 2000. Nurses are the major health care providers in a PHC setting and they play a leading role in fostering community participation in PHC. In the midwifery section, midwives foster community participation by collaborating with the newly delivered mothers and their families. As hospital stays shorten, the role of a midwife must be to work toward the goal of postpartum home care as a way of providing care. The midwife must be able to assess rapidly and accurately the postpartum patient's needs, make the appropriate nursing diagnoses, and develop strategies to use this time most effectively in addressing the unique needs of each individual.

Keppler (1995) has demonstrated that the economic pressures to reduce health care costs have resulted in shortened hospital stays, including those of maternity patients. Williams and Cooper (1993) state that nursing care that historically included a focus on the physical and emotional adaptation of the mother, newborn and family can no longer be accomplished because of the decreased length of hospitalisation. Women are leaving the hospital within 24 hours of a vaginal delivery and within 2-3 days of a Caesarian section

(Keppler, 1995). Keppler (1995) argues that mothers leave the hospital when they are just beginning to recover from giving birth and beginning to learn about parenting. Gagnon, Edgar, Kramer, Papageorgiou, Waghorn and Klein (1997) commented that the organisation of early postpartum discharge programs by hospitals and communities is a challenging task. They further argue that hospital nursing care will likely need to be reorganised in response to an increase in severity of women's conditions as short postpartum hospital stays are put into place. They recommend that respo- ibility for the health of these mothers and newborn infants will need to be clearly delineated between hospitals and communities once they return hom:. Keppler (1995) recommends that infants leaving the hospital within 24 hours of birth be seen for evaluation and support within 48 hours of discharge. Paavilainen and Astedt-Kurki (1997) state that the choice of early discharge should always be voluntary and may be recommended primarily for those families who are not first time parents. While Brumfield, Nelson, Stotzer, Patterson, Sprayberry & Shannon (1996) conclude by saying that in selected, low risk populations, mother-infant discharge at 24 hours postpartum with a home follow-up visit is safe and cost effective. Pridham, Lytton, Chang and Rutledge (1991) recommend that more research is needed to develop a model of early postpartum transition, to help nurses focus and determine the areas of emphasis in early postpartum nursing intervention. They further argue that 24-36 hours postpartum may be too soon after delivery for mothers to absorb additional information. In Botswana, the policy is to discharge postnatal mothers within 24 hours post-delivery.

1.2 STATEMENT OF THE PROBLEM

There has been little research conducted in Botswana about postnatal care in hospitals. To the researcher's knowledge no attempt has been made to determine women's perceptions of early postpartum discharge from hospital.

In Francistown, mothers leave hospital when they are just beginning to recover from giving birth and beginning to learn about parenting. Postnatal care immediately after delivery is important to provide the necessary preventive care and teaching to the postpartum mothers before discharge. It also enables the midwife to provide appropriate comprehensive home care through empowerment.

1.3 PURPOSE OF THE STUDY

The purpose of the study was to investigate women's perceptions of early discharge after childbirth and to determine their needs. This study aimed to create an awareness that could lead to improved service and meet the needs of postnatal women. The study also aimed to influence the education of health care personnel to be responsive to different perceptions of postnatal care in our society. During in-service education, health care personnel can be enlightened that postnatal care mothers have individualised needs that need to be addressed. Once they are enlightened, it would be hoped that they will render individualised care.

1.4 SIGNIFICANCE OF THE STUDY

Williams and Cooper (1996) state that shortened hospital stays have decreased women's access to postpartum nursing care. These early discharges have decreased opportunities for women to assimilate the mothering role with the help of the health care providers. It is therefore appropriate to conduct research to determine the effects of early postpartum discharge on the mother.

1.5 RESEARCH QUESTIONS

- What are the perceptions of postpartum women in relation to early postpartum discharge?
- What are the needs associated with and the problems experienced with early postpartum discharge?

1.6 OBJECTIVES OF THE STUDY

- To determine the perceptions of postpartum women in relation to early postnatal discharge.
- To identify problems experienced with early postpartum discharge.

1.7 OPERATIONAL DEFINITIONS

- ***Six weeks postpartum mother:*** mother who delivered her baby six weeks ago.
- ***Early postpartum discharge:*** A discharge from hospital which takes place 6 to 24 hours post-delivery.
- ***Perceptions:*** Women's feelings, views or opinions about early postpartum discharge.
- ***Single parent:*** Women who are not traditionally nor legally married.

1.8 ASSUMPTIONS

- Any postpartum woman willing to be interviewed will be truthful.
- Women will welcome the opportunity to discuss their perceptions with an empathetic and supportive listener.
- The perceptions of the postpartum women may differ according to age, parity, educational background, occupation, marital status, hours stayed in hospital, information given in hospital and problems encountered by postnatal mothers.

1.9 LIMITATIONS

- The findings of this research are limited to the five clinics and because of the sampling technique used they cannot be generalised for these five clinics.

- The questionnaire was formulated in English and translated to Setswana. Some meaningful ideas may be lost.
- The sample was biased as it only sampled women from five of the clinics.
- The research was conducted in only one urban setting. Therefore, findings can not be generalised beyond the sample.

1.10 CONCLUSION

In this chapter, an overview of the research study is presented. The research problem is identified and outlined. The research questions, objectives of the study, operational definitions, assumptions and limitations were also presented.

CHAPTER 2

LITERATURE REVIEW

In this chapter the literature is reviewed in relation to perceptions of early postpartum discharge, reasons for early discharge, the role of the midwife during early postpartum discharge, problems associated with early postpartum discharge and home follow-up after discharge.

2.1 DEFINITION OF EARLY POSTPARTUM DISCHARGE

It appears to be a global trend to discharge women early after delivery. This may be as early as 6 hours post-delivery. In Sweden, early discharge refers to discharge from hospital 6-72 hours postpartum (Kvist, Persson & Lingman, 1996, p. 85). In Finland, reporters such as Paavilainen and Astedt-Kurki (1997, p. 266-267) state that early discharge from maternity hospital refers to a situation where the mother and newborn are monitored and treated in hospital for 6-24 hours before leaving the hospital.

In America, one of the more frequently used cost containment measures is shortening postpartum hospital stay (Sheil, Bull, Maxon, Muehl, Kroening, Peterson-Palmbers & Kelber, 1995, p. 149). They go on to state that mothers are often discharged within 24 hours of delivery.

In the United States of America, it is also reported that in response to health care cost and consumer demand, the length of stay ranges from 2 to 24 hours after childbirth (Brown, Towne & York, 1996, p. 332). Fishbein and Burggraf (1998, p. 149) report that the average hospital stay after uncomplicated vaginal delivery in America, has decreased from 48 hours to as early as 6 hours after the birth. Hall and Carty (1993, p. 574) in their illustration of the Canadian situation, defined early postpartum discharge as discharge from hospital 12-24 hours after birth. Whilst in Botswana, early postpartum discharge is discharge from hospital 6-24 hours after delivery of the baby.

2.2 REASONS FOR EARLY POSTPARTUM DISCHARGE

Waldenström (1989, p. 189) using a semistructured interview schedule, interviewed 230 women telephonically. The researcher studied the effects of "voluntary and involuntary" early postnatal discharge on women's experiences of early discharge. He learned that promotion of family oriented postnatal care is one reason for introducing early discharge programmes. The researcher found that women choosing to go home soon after the birth and who receive home visits are usually very satisfied with this alternative.

Hall and Carty (1993, p. 574) gathered data in unstructured interviews with eight women. The purpose of this study was to understand women's experiences in an early discharge programme. Their findings revealed that health care professionals are embracing early discharge programmes as one strategy for reducing health cost. Nevertheless, they

identified that areas such as maternal infant attachment, father and sibling involvement and patient satisfaction had not been explored.

Paavilainen and Astedt-Kurki (1997, p. 270) in data collected from focus group interviews and hospital documents, found that early discharge from hospital made it possible for parents to take care of the well-being of their older children. They found that early discharge was also seen as one way of facilitating the acceptance of the baby among other children in the family. The results further revealed that the home was also a protective place to which the family felt the sense of belonging.

Reasons for wanting to leave hospital early are known to vary. Small, Lumley and Brown (1992, p. 175) conducted a survey using a mailed questionnaire involving a population based sample of 1193 women who had given birth in one of two weeks during February or September 1989. Women were sent a postnatal survey 8-9 months after the birth of their baby. The findings of the study revealed that some women wished to go home early in order to promote family togetherness, whilst others do so because they have a personal or cultural discomfort with hospitals. The above statement is further supported by Waldenström (1989, p. 189) who states that early discharge gives the family an opportunity to re-unite in a natural setting soon after birth.

Brown, Towne and York (1996, p. 333) have written that early postpartum discharge programs are emerging as one strategy for reducing health care costs and, in some areas, relieving the shortage of hospital beds. They reported a savings of 2143 hospital stays in

a three year period of operating a 24 hour early discharge program. The researchers included women aged 18-50 with no medical or obstetric complications, who were discharged less than 48 hours post-delivery. The study revealed that early discharge programs can prevent iatrogenic problems and the occurrence of nosocomial infections in both the mother and the baby. In addition, it reunites families earlier and reduces the overall cost of care. Virtually all of these women (97.8%) had some help at home during the first week after delivery.

Carty and Bradley (1991, p. 171) in their randomised controlled study of 131 women of early postpartum hospital discharge, found that more early discharge mothers were breast feeding without having to give supplementary feeds at one month as compared to mothers in the long stay group. Mothers in the early discharge groups were significantly more satisfied with their care than were those who remained in hospital longer.

2.3 THE ROLE OF THE MIDWIFE DURING EARLY POSTPARTUM DISCHARGE

Laryea (1984, p. 27) states that the midwife must assess the needs of the mother, know her general ability to cope with situations, the problems facing her at present and possibly anticipate problems which may arise in the future. Midwives in hospital should perform a thorough physical examination before discharge. This includes vital signs, assessment of pallor, breast activity, uterine involution, lochia for colour and odour, state of the

episiotomy, counselling on breastfeeding and baby care (Safe Motherhood Initiative, SMI, 1994).

Beger and Cook (1998, p. 161) state that as a result of shortened postpartum stays, it is necessary to identify priority maternal learning needs and develop effective, efficient educational programs. They further state that currently, agreement exists across studies on the importance of several maternal learning needs such as infant illness, cord care, infant feeding and episiotomy care. Smith (1989, p. 182) in his findings of a sample composed of 19 primiparae and 22 multiparae identified that there was a need for professional emphasis on support soon after discharge, and that primiparae should receive additional assistance and support in areas of baby care. Despite the small size of this sample, the findings are noteworthy.

Pridham, Lytton, Chang and Rutledge (1991, p. 21) suggest that the progress of maternal/infant adaptation in the first few days after the infant's birth, is likely to predict needs after hospital discharge and is important for nurses to assess. Clark (1995, p. 547) concludes by saying that the nurse is increasingly challenged to find efficient and cost-effective methods of providing outpatient care, teaching and counselling. He further argues that provision of these services will decrease costs to women and society by providing the benefits.

2.4 PROBLEMS ASSOCIATED WITH EARLY POSTPARTUM DISCHARGE/ INFORMATION

Williams and Cooper (1996, p. 745) state that shortened hospital stays have decreased womens' access to postpartum nursing care. They recommend that providers and payers together must address clinical and cost issues to develop a mode of maternity care that covers the postpartum period. Gagnon *et al* (1997, p. 210) in a randomised controlled trial in a 637 bed university hospital in Canada, included 175 healthy women recruited at 32-38 weeks gestation. Experimental intervention consisted of women discharged 6-30 hours postpartum with nursing care available by telephone. Their findings suggest that shorter hospital stays are not universally acceptable. The extent to which acceptability can or should be incorporated into the implementation of such programs is a topic of debate.

Tribotti, Lyons, Blackburn, Stein and Withers (1988, p. 412) in their study of 231 women who were sampled by the convenience method, 12-72 hours after birth, revealed that with the current trend of short hospital stays, the time available for nursing assessment and intervention with hospitalised postpartum families has decreased. They argue that primiparae were significantly more likely than multiparae to identify a knowledge deficit. They suggest that women continue to need intensive nursing assessment and intervention throughout their stay. They further argue that the effects of transferring the burden of care from professionals in hospital to family members in homes need to be examined. They comment that the organisation of early postpartum discharge programs by hospitals

and communities is a challenging task. The authors further recommend that hospital nursing care will need to be reorganised in response to an increase in severity of women's conditions as short postpartum hospital stays are put into practice. They go on to state that nurse's home visitations was an integral part of the program.

Brown and Johnson (1998, p. 34) in their study of 41 mother-infant dyads, issued a questionnaire 24-48 hours after vaginal delivery to mothers aged 18 years and more. They found that knowledge deficit related to infant or self-care was an appropriate diagnosis for 97% of the participants in the project group, and 80% needed assistance in obtaining additional resources. Some women were uncertain about how to care for themselves in the postpartum period, whereas others (75%) lacked basic information needed to provide care for their infant.

Fishbein and Burggraf (1998) state that the disadvantages of early discharge programs include the increased possibility of readmission, loss of employment by other care-giving family members, complications that may go undetected, psychological problems that may be overlooked and health care providers who are unavailable to provide assistance when problems arise. Fishbein and Burggraf (1998) further comment that the women's early concerns about themselves relate primarily to perineal sutures, breast care, fatigue and return of their figure to normal. Their findings suggest that additional education by nurses in hospitals about care of sutures and breast discomfort is needed. Their study also found that 25% of mothers were depressed at two weeks postpartum. Lastly they conclude that the transition to parenthood is a time of significant physical, emotional and

psychological change for families. They further stated that opportunities exist for nurses to address the concerns of mothers and their families. They recommend that research needs to be done on parents to evaluate the effectiveness of existing and new interventions in relation to the care given post-delivery.

Pridham Lytton, Chang and Rutledge (1991) distributed a questionnaire and letter of informed consent to 300 postpartum mothers admitted to a 44-bed community hospital. Only 140 mothers completed and returned the questionnaire. They found that primiparae had less confidence and satisfaction in mothering than multiparae at day 3 postpartum. They identified that multiparae reported greater confidence in doing infant care tasks.

Smith (1989, p. 185) found that the primiparae studied had more major concerns related to learning to care and to meet the needs of a dependent baby. The researcher further identified that the primiparae required information about babies and practice with baby care. In addition, he noted that postnatal teaching in hospitals emphasises the task of learning to care for and meet the needs of a dependent baby more so than any of the other tasks. Smith (1989) further argues that the information and assistance received by the majority of these primiparae in the first postpartum month was not sufficient. He states that for various reasons, for example, fatigue and nervousness, the women had not been able to assimilate the information. The researcher recommended that the home setting, which allows the midwife or nurse the opportunity to use the resources in the woman's own environment, is perhaps the most appropriate setting for teaching.

Haller (1995 p. 205) emphasizes that patient education is an integral part of women-centred care and that it is an approach that entails providing information for people about health-related matters. Haller (1995) in quoting other studies, revealed that patients in hospital are usually dissatisfied with the amount of information they receive from staff. Brown, Towne and York (1996, p. 334) suggest that the physical and psychological state of the mother has a major influence on the woman's ability to retain new information in the first 24 hours postpartum. They further indicate that the typical postpartum mother experiences a significant cognitive deficit, especially of memory in the first 24 hours after birth. The researchers conclude by saying that the postpartum period is generally a poor time for patient teaching for a wide variety of physical and psychological reasons, for example, fatigue.

Beger and Cook (1998, p. 165) conducted a cross sectional study, utilising a convenience sampling technique. They issued questionnaires to mothers during their postpartum stay. The questionnaire required the mothers to rate the importance of learning 44 maternal-infant topics before discharge. Two hundred and thirty-six mothers and 201 obstetric nurses were asked to participate in the study. Their findings revealed that mothers and nurses were in agreement that postpartum topics are of importance, for example postpartum complications, stitches/episiotomy and medications. Nearly 74.4% of nurses considered breast care to be a very important learning need, while only 48.7% of the mothers agreed. Both nurses and mothers (47.6% and 30.8% respectively) reported mood changes as very important. Beger and Cook (1998) reported that the majority of the mothers and nurses rated nearly half of the topics as very important. Feeding, cord care,

infant illness, elimination patterns and jaundice were topics considered to be important by both groups. In the same study, the researchers found that first time mothers considered maternal topics more important than did experienced mothers. In conclusion, Beger and Cook (1998) support the observation that first-time mothers request more information on infant topics. They recommend that the individual learning needs of different groups of mothers needs to be accommodated when possible.

According to Regan and Lyndon-Rochelle (1995, p. 31) mothers and newborns are being discharged from the hospital without the majority of their post-delivery health care needs being met. With early discharge becoming the norm, providing necessary information to the new mother needs to be determined. Regan and Lyndon-Rochelle (1995) argue that there is a great deal for a new mother to learn. It is not possible for the mother to absorb all the information given within a short period of time. They recommend that investigations into the most effective way to provide vital information deserve greater emphasis.

Brown and Johnson (1998, p. 37) support the above statement by arguing that early hospital discharge of mother and infant also decreases the opportunities for women to learn the mothering role with the help of health care providers. The writers go on to state that because of time constraints, the hospital experience for new mothers is intense. She is expected to give birth, undergo marked physiologic changes, adapt to her newborn and learn the skills needed to care for herself and her infant in the allotted 24 hours. They argue that primiparae would be disadvantaged by shorter lengths of stay. Their argument

is that primiparous women would suffer because they would not develop the confidence to be gained by continual access to expert advice in hospital. Brown and Johnson (1998) found that, including additional information in the discharge teaching of new mothers in the hospital to address areas of weakness, is not a realistic option. During the follow-up survey, they found that women frequently spoke of being overwhelmed with information. Often they were too tired or too sore to comprehend information presented to them.

Meeting the educational needs of families in the postpartum period has always been a nursing challenge, but it is especially so when women are discharged 6-24 hours after delivery (Mendler, Scallen, Koutun, Balesky & Lewis, 1996, p. 242). Mendler *et al* argue that a number of studies have revealed that education and support needed by families would be best achieved during home visits. Serwint, Wilson, Duggan, Mellits, Baumgardner and DeAngelis (1991, p. 448) argue that mothers who met the health care worker within the first week of the baby's life, were much more receptive to the advice given to them than mothers who first met health care workers at six weeks postpartum.

2.5 EARLY DISCHARGE AND FOLLOW-UP CARE

Without follow-up care, most of these new mothers would need to rely on friends or relatives for essential health care information. Home follow-up care can provide a cost-effective method of care during these transitional periods. On the other hand, early identification of problems and appropriate interventions can reduce health care

expenditures and decrease stress in the new, developing families (Brown & Johnson, 1998, p. 37).

Brown, Towne and York (1996, p. 335) state that postpartum teaching can be done during a home visit, reinforcing information given in the hospital or birthing centre. Brumfield, Nelson, Stotzer, Patterson, Sprayberry and Shannon (1996, p. 327), screened women 24 hours after discharge to determine their eligibility for 24 hour discharge. The results revealed that of 5170 deliveries, 812 mothers (16%) and 707 (14%) newborns were discharged home at 24 hours. They found that mother-infant discharge at 24 hours postpartum with home follow-up visit is safe and cost effective.

Serwint *et al* (1991) suggest that educational sessions, once the mother and baby are at home, within the first week of life, may be more effective than six weeks postpartum. In addition, they suggested that the content and quality of the providers teaching sessions be considered.

The above statement is further supported by Kenny, King, Cameroon and Shiell (1993, p. 152) who studied satisfaction with postpartum care. Their findings revealed that no increased morbidity had been demonstrated for women or babies in these studies. They stated that provided there was home follow-up by a midwife and successful maternal postpartum adjustment, morbidity will be decreased.

Kenny *et al* (1993) further identified that women taking early discharge involuntarily were more likely to experience problems, such as fatigue than women discharged voluntarily on the same postnatal day. They concluded that early discharge should remain optional.

Mendler *et al* (1996, p. 243) argue that some women, knowing they will receive support in their home environment, are eager to go home early. The choice of early discharge should always be voluntary and may be recommended primarily for those families who are first-time parents. Writers, such as Mendler *et al* (1996) recommend that research is needed on the health experience of fathers and of first-time families living in similar life situations, as well as the experiences of children having a new sibling.

Williams and Cooper (1993, p. 25) support the above statement by saying that a standard of care addressing the postpartum needs of mothers, newborns and families with shortened hospital stay has not been establish . They further suggest that postpartum home nursing care should be established as a priority of maternal nurses.

The review of the literature suggested that follow-up services, in which nurses visit new families in their homes within a few hours or days of discharge, can bridge the gap in health care that exists between early discharge and routine check-ups. Williams and Cooper (1993) argue that a follow-up visit allows nurses to provide valuable education and support services to new families in a safe and cost-effective manner.

2.6 CONCLUSION

The review of the literature suggests that mothers' perceptions about early postpartum discharge are wide ranging. Literature has shown that the trend world-wide is to discharge women early after birth (as early as 6-24 hours). Reasons given in favour of early discharge include reduction in hospital costs and bed capacity. Problems that have been associated with early discharge are:

- lack of information and,
- lack of adequate care from early postpartum discharge.

The literature suggests that follow-up care within the first week of life after discharge should be recommended.

In the next chapter, the research methodology and ethical considerations will be described.

CHAPTER 3

METHODOLOGY

In this chapter, the method of the study including the design, setting, population, sample, data collection procedure, instrument and ethical considerations will be described.

3.1 RESEARCH DESIGN

A descriptive research design was used. It describes characteristics, opinions, attitudes or behaviours as they exist in a population (Wilson, 1993, p. 121). This approach is appropriate to the purpose of this study since very little is known about the perceptions of postpartum mothers regarding early discharge from hospital. To the researcher's knowledge, no research has been undertaken in this regard in Botswana.

3.1.1 Setting

The study was conducted in Francistown, Botswana. Francistown is the second largest city in the northern part of Botswana (see Annexure A). According to the projected census of 1991, Francistown has a population of 65,244 of which 33,579 are women (Central Statistics Office, 1992). The city has a total of ten primary health care clinics offering maternal and child health/family planning services. The distance between the clinics is about 3-5 kilometres. This makes the clinics geographically accessible to the clients (See Annexure B). It is the second largest referral hospital in the country, which

started operating in 1989. It acts as a referral facility for the northern district hospitals in the city. It has 40 postpartum beds.

3.1.2 Population

The target population for the study consisted of postnatal mothers, primiparae and multiparae, who had had a normal vaginal delivery, and who were six weeks post-delivery. According to a preliminary record review, an average of 2-3 postnatal mothers attended each clinic per day. This implied that an average of about 60 postnatal mothers attended each clinic every month and 600 postnatal mothers attended the ten clinics in Francistown every month.

3.1.3 Sampling Method

In consultation with a statistician, a sample size of 110 was calculated to be adequate.

- Simple random sampling was used to select five clinics for the study.
- Random numbers were assigned to each of the ten clinics in Francistown that is from 01 up to 10.
- The researcher utilised a table of random number in a systematic way downwards, choosing them by picking those clinics whose numbers corresponded to the table of random number (Wilson, 1993).

Three of the clinics are situated in the eastern part of the city centre, while the other two are in the western part of the city centre.

A sample of at least 22 postnatal women was obtained from each clinic. A minimum sample of 110 postnatal women was required from the five clinics over a period of three weeks. The clinics were visited on a daily basis between 07:30 - 12:30p.m. When the target was not reached or subjects were not available, the clinics were revisited by the researcher until the minimum target of 22 respondents was reached. In this way an effort was made to ensure equal representiveness of each clinic in the sample.

Convenience sampling was used to interview women (that is women were interviewed as they arrive at the clinic). As the name suggests, a convenience sample consists of units which are readily or conveniently available (Polit & Hungler, 1993)

Inclusion criteria for the sample were:

- Women who had had a normal delivery, and who were discharged from hospital 6-24 hours post-delivery, regardless of parity.

Exclusion criteria used were:

- Mentally retarded mothers.
- Mothers discharged 24 hours after delivery.
- Age - less than 18 years. These mothers have special needs that need to be studied on their own.

Age - more than 49 years.

- Home deliveries.
- Mothers who delivered stillborn infants or who had experienced a neonatal death.
- Women who had had a Caesarian section.

3.1.4 Research Instrument

A structured interview schedule was utilised. The interview schedule consisted of two sections: the first section of the schedule consisted of demographic data, for example, age, marital status, number of children, occupation and level of education. The second section consisted of both close-ended and open-ended questions. It elicited postnatal women's perceptions in relation to early discharge, as well as allowed for the collection of more subjective data, such as negative and positive perceptions in relation to early postpartum discharge from hospital. Interviews allow researchers to collect data from people who, either because of their literacy level or some other communication barrier, are unable to write (Wilson, 1993). Questions were developed from the literature, records, experience, obstetric and gynaecologic experts. The interview schedule was formulated in English and translated into Setswana (see Annexure C).

3.1.5 Pilot Study

A pilot study comprising five women was carried out in one of the sampled clinics. These women did not form part of the sample. No adjustments and corrections were made to the interview schedule after the pilot study was undertaken.

3.1.6 Data Collection Procedure

Data was collected over a 3 week period in the month of July, 1998. Participants in the five clinics mentioned who met the criteria and who were willing to participate in the study were interviewed using a structured interview schedule. The purpose and the nature of the study was explained to the subjects and instructions were clarified.

The time allocated for an interview was 15-30 minutes. The interview was conducted by the researcher. Before each interview, the researcher read an information letter to each respondent to enable the client to give an informed verbal consent (see Annexure D).

The participants were given the option to withdraw from the interview at anytime if they so wished. The respondents were also informed that their participation or non-participation would not influence the type of care they received. Anonymity was ensured whereby names were not given and the researcher completed the interview guide. Clients participating in the research were reassured that all information given would be treated as confidential.

Verbal consent was obtained from each individual interviewee before commencement of the interview because there were some respondents who could not read nor write.

3.1.7 Validity and Reliability

The interview schedule was evaluated by the researcher's supervisor, midwifery colleagues and three experts in the field of obstetrics, gynaecology and midwifery to ensure face validity. The pilot study was conducted on five respondents to ensure content validity. According to Wilson (1993), content validity is an assessment of an instrument to ensure that it measures what it is suppose to measure.

Reliability was ensured by using a structured interview schedule to interview all the respondents. This ensured that questions were asked in the same order. The researcher conducted the interviews herself, thus probing techniques were standardised.

3.2 DATA ANALYSIS

Data was analysed by means of a computer using the Statistical Package for Social Sciences (SPSS). This programme was used to generate descriptive statistics which examined the background information, frequency distribution and percentages for the sample. Graphs and tables were used to describe results.

3.3 ETHICAL CONSIDERATIONS

Permission to undertake this research was obtained from the following institutions and individuals:

- The researcher applied for clearance to conduct research from the Committee for research on human subjects of the University of the Witwatersrand (see Annexure E, Protocol number M980543).
- Permission was obtained from the Francistown City Council Health Department through the city matron before the research was conducted. A written consent was given (see Annexure F, Reference Number FCC/47).
- Sisters-in-charge of the clinics.
- Respondents themselves.

3.4 CONCLUSION

This chapter described the method of the study including the design, setting, population, sample, data collection procedure, instrument and ethical considerations.

In the next chapter, the findings of the study will be described.

CHAPTER 4

FINDINGS AND DISCUSSION OF FINDINGS

This chapter is divided into two sections: Section A, describes the demographic characteristics of the respondents. Section B, describes the perceptions of postpartum women in relation to early discharge, the problems which were identified and the information which was given on discharge. Use will be made of descriptive statistics, tables and figures to describe the findings.

One hundred and ten post-partum mothers were interviewed in five clinics in Francistown, Botswana.

4.1 SECTION A

4.1.1 Demographic Data

4.1.1.1 How old are you?

The majority of the respondents (54.2%) were between the ages of 18 and 25 years. May and Mahlmeister (1994, p. 219) state that the age of 35 years and over is an age where

psychologically, women feel optimally prepared for the demand of pregnancy and parenthood

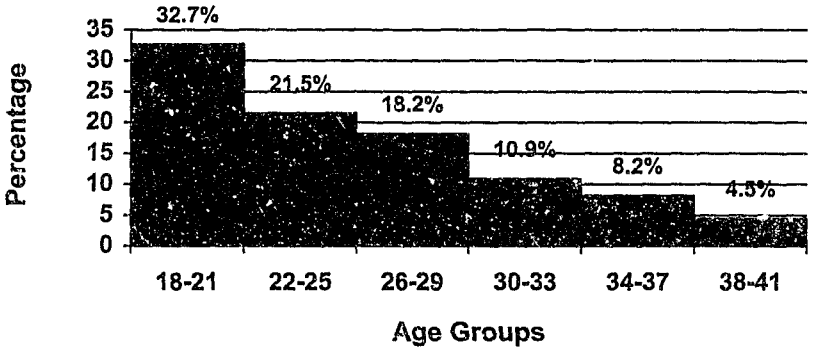

Figure 4.1: The age distribution of respondents (n = 110)

4.1.1.2 Are you married?

Figure 4.2 shows that 86.4% of respondents were single. Thus these mothers may need a lot of support from the midwives and their family. No respondents were divorced, separated or widowed.

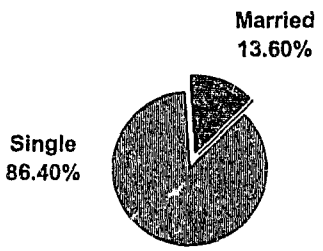

Figure 4.2: Marital distribution of respondents (n = 110)

4.1.1.3 How many children do you have?

The graph shows that 32.7% of respondents were first time mothers (primiparas). The majority of the respondents, 67.3%, had two or more children (multiparae). Research done by, for example, Tribotti *et al* (1988) and Smith (1989), have shown that multiparae report greater confidence in doing infant care tasks than primiparae.

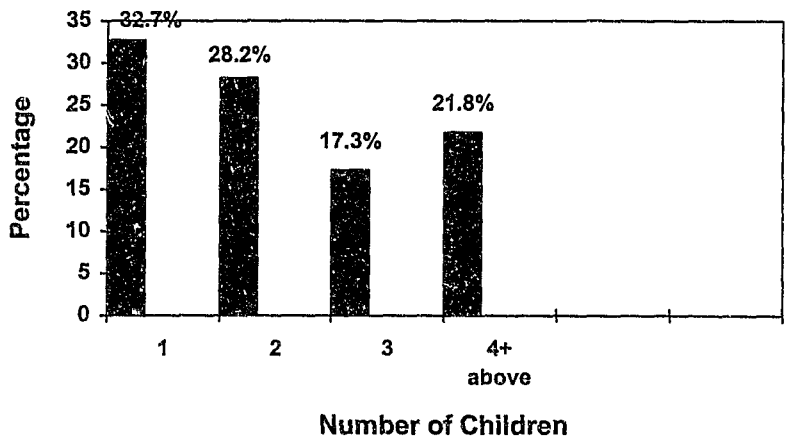

Figure 4.3: Number of children (n = 110)

4.1.1.4 What is your highest educational qualification?

The Botswana school system is such that:

- Primary school ranges from Standard 1 to 7.
- Junior secondary school from Form 1 to 3.
- Cambridge from Form 4 to 5.

- In this study, other refers to those who did not attend or never attended school.

The majority of the respondents had attended school (91.8%). More than half (64.6%) of the respondents had an educational level ranging between form 1 and 5.

Table 4.1: Educational qualifications of respondents (n = 110)

YEARS OF SCHOOLING	FREQUENCY	PERCENT
Primary school	28	25.4
Junior Secondary	53	48.2
Cambridge	18	16.4
Postgraduate	2	1.8
Other	9	8.2
TOTAL	**110**	**100.0**

4.1.1.5 Are you working?

The majority of the respondents (71.8%) were unemployed while 28.2% were employed. Of the 28.2% (n = 31) who were working, 20.9% were permanently employed and 7.3% were in temporary employment. It would appear therefore, that more than two-thirds of the respondents in this study depend on their family members/partners financially.

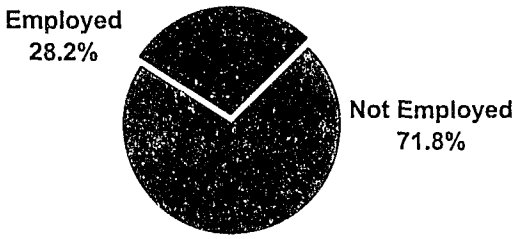

Figure 4.4: Employment status of respondents (n = 110)

4.2 SECTION B

In this section, perceptions of postpartum women in relation to early postpartum discharge are described.

4.2.1 Perceptions

4.2.1.1 When were you discharged from hospital after delivery?

In order to analyse perceptions more accurately, respondents were asked how soon after delivery they had been discharged.

Table 4.2: Number of hours after delivery and of discharge from hospital (n = 110)

HOURS OF DISCHARGE	FREQUENCY	PERCENT
6 hours	2	2.8
7-10 hours	28	25.4
11-15 hours	32	29.1
16-20 hours	29	26.4
21-24 hours	19	17.3
TOTAL	**110**	**100.0**

The results show that 80.9% of the respondents were discharged between 7 and 20 hours after delivery. Of the 80.9% who were discharged in this time period, 32.6% were primiparae.

4.2.1.2 Did you feel ready to leave hospital at this time?

Table 4.3: Distribution of respondents ready to leave hospital (n = 110)

DID YOU FEEL READY?	FREQUENCY	PERCENT
Yes	76	69.1
No	34	30.9
TOTAL	**110**	**100.0**

The findings show that 76 (69.1%) of the respondents were ready to leave hospital. Of the 76 [illegible]), 16 (21.1%) were primiparae and 60 (78.9%) were multiparae.

The majority, 76 (69.1%), of the respondents gave reasons that they were ready to go home to be cared for by their family members. Twenty-two (28.9%) of the respondents (n = 76) stated that they were ready to go home to care for their children. Postnatal mothers are usually eager to leave the hospital to be with their families. Mendler *et al* (1996, p. 243) argue that some women, knowing that they will receive support in their home environment, are eager to go home early. Similarly, Paavilainen and Astedt-Kurki (1997, p. 270), found that the early discharge from hospital made it possible for parents to take care of the well-being of their older children.

However, 34 (30.9%) of the respondents were not ready to go home. Of these, 20 (58.85%) were primiparae. The reasons they gave were that they had painful stitches, and that they did not know how to bath and take care of their newborn babies. This is consistent with Smith's findings (1989). In his study primiparae had major concerns

related to learning to care for or meet the needs of a dependent baby. He further identified that primiparae required information about babies and practice with baby care. Fourteen (41.2%) of the 34 (30.9%) who were not ready to go home, were multiparae. The reasons they gave were that they were not physically fit. They stated that they had dizziness, headache and fatigue. Fishbein and Burggraf (1998) suggest that the women's physiologic concerns during the early postpartum period are related primarily to perineal sutures, breast care and fatigue.

4.2.1.3 Is it good to be discharged early?

Table 4.4: Distribution of respondents who felt it is good to be discharged early

(n = 110)

IS IT GOOD?	FREQUENCY	PERCENT
Yes	69	62.7
No	41	37.3
TOTAL	110	100.0

In this study, the majority of the respondents (62.7%) felt that it was good to be discharged early. Of the 69 (62.7%) who stated that it was good to be discharged early, 16 (23.2%) were primiparae and 53 (76.8%) were multiparae. Of the 69 (62.7%) who stated that it is good to be discharged early, more than half, 38 (55.1%) felt that the nurses did not assist them in hospital. This is in contrast to Carty and Bradley's (1991) findings

that mothers in early discharge groups were significantly more satisfied with their care than were those who remained in hospital longer.

Of the 41 (37.3%) respondents who felt it was not good to be discharged early, more than half, 24 (58.5%), were primiparae. The reasons that they gave were that they were still physically unfit (fatigue and dizziness) and that they were lacking information in relation to care of the baby and self.

Of the 17 (41.5%) multiparae who felt it was not good to be discharged early, 11 (64.7%) stated that they were still feeling dizzy and had fatigue. The remaining 6 (35.3%) stated that they were unhappy because they were asked to go home due to a shortage of beds. Brown, Towne and York (1996) have written that early postpartum discharge programs are emerging as one strategy for reducing health care costs and in some areas, relieving the shortage of hospital beds.

4.2.1.4 Do you think you needed more time in hospital?

Table 4.5: Distribution of respondents who needed more time in hospital (n = 110)

NEED MORE TIME	FREQUENCY	PERCENT
Yes	40	36.4
No	70	63.6
TOTAL	110	100.0

The majority of the respondents 70 (63.6%) stated that they did not need more time in hospital. Of the 70 (63.6%) who did not need more time in hospital, 13 (18.6%) were primiparae and 57 (91.4%) were multiparae. Of the 70 (63.6%) respondents who said no, 58 (82.9%) stated that they did not need more time in hospital because they were physically fit. Twelve (17.1%) felt they did not like the hospital. Small, Lumley and Brown (1992) found that some women wish to go home early because they have personal or cultural discomforts with hospitals.

Forty (36.4%) of the respondents needed more time in hospital. Of the 40 (36.4%), 23 (57.5%) were primiparae and 17 (42.5%) were multiparae. All the responses from the primiparae (57.5%) were that they needed more time to be given more information in relation to baby care (bathing and feeding) and how to care for the stitches. Haller (1995) emphasises that patient education is an integral part of women centred care and that it is an approach that entails providing information for people about health related matters.

Of the 17 (42.5%) multiparae, 15 (88.2%) felt that they were not physically fit and felt that they had dizziness, headache, and fatigue. The remaining two (11.8%) felt that they needed rest in hospital.

4.2.1.5 When would you have liked to be discharged?

Table 4.6: Distribution of what time mothers wanted to be discharged (n = 110)

WHAT TIME	FREQUENCY			PERCENT
		Primiparae	Multiparae	
6 hours	4	0	4	3.6
>24 hours	4	0	4	3.6
>72 hours	1	1	0	0.9
3 days	16	7	9	14.5
7 days	15	12	3	13.6
Other	70	16	54	63.6
TOTAL	**110**	**36**	**74**	**100.0**

"Other" refers to the mothers who felt that the time of discharge was appropriate for them..

Of the 40 (36.4%) respondents who opted to be discharged between 6 hours to 7 days, four (10%) of the multiparae wanted to be discharged within 6 hours. None of the primiparae wanted to be discharged within 6 hours whereas four multiparae interviewed wanted to be discharged after 24 hours. One (2.5%) of the primiparae wanted to be discharged after 72 hours and 12 (16.2%) of the multiparae opted to be discharged after 72 hours.

Nineteen (52.8%) of the primiparae wanted to be discharged between 3-7 days and 12 (16.2%) of the multiparae also wanted to be discharged at the same time. The majority of the respondents 70(63.6%) stated that the timing of discharge was appropriate for them.

4.2.1.6 Were you happy with when you were discharged?

Table 4.7: Distribution of respondents happy with when they were discharged

(n = 110)

HAPPY WITH DISCHARGE	FREQUENCY	PERCENT
Yes	78	70.9
No	32	29.1
TOTAL	**110**	**100.0**

Of the 78 (70.9%) respondents who were happy with when they were discharged, 20 (25.6) were primiparae and 58 (74.4%) were multiparae. All the respondents, 78 (70.9%) who were happy with when they were discharged, stated that they were going to obtain help/assistance from family members. Of the 32 (29.1%) respondents who were not happy with when they were discharged, 16 (60%) were primiparae. Reasons they gave were that they felt they lacked information on how to care for themselves. According to Brown and Johnson's study (1998) done in the United States some women were uncertain about how to care for themselves in the postpartum period, while 75% lacked basic information needed to provide care for their infants. In this study 16 (50%) of the respondents who were not happy with when they were discharged were multiparae. They stated that they had fatigue and felt they should have stayed in hospital longer in order to rest.

4.2.1.7 Did you experience any problems at home after discharge?

Table 4.8: Distribution of wnether problems were experienced at home (n = 110)

PROBLEMS EXPERIENCED	FREQUENCY	PERCENT
Yes	43	39.1
No	67	60.9
TOTAL	**110**	**100.0**

More than half of the respondents, 67 (60.9%) did not experience any problems at home after discharge. Of this number 14 (20.9%) were primiparae and 53 (79.1%) were multiparae. Reasons given by those who did not experience problems were that they were physically fit and that they were assisted by their family members at home.

Of the 43 (39.1%) respondents who experienced problems after discharge, half (22) (51.2%) were primiparae. Reasons given by those who experienced problems were as follows: 25 (61.2%) indicated that they were physically unfit (dizziness, headache and fatigue); while five (11.6%) stated that there were no relatives at home to assist them; 13 (30.2%) of the respondents felt that they were unable to bath and breastfeed their new born babies as well as care for the painful stitches.

4.2.1.8 Were you given information on the following in relation to your baby?

Table 4.9: Distribution of information given to the mothers in relation to the baby:

(n = 110)

		FREQUENCY	PERCENT
Eye care	Yes	7	6.4
	No	103	93.6
Cord care	Yes	46	41.8
	No	64	58.2
Buttock care	Yes	16	14.6
	No	94	85.4
Skin care	Yes	13	11.8
	No	97	88.2
Care of nappies	Yes	17	15.5
	No	93	84.5
Baby bathing	Yes	32	29.1
	No	78	70.9
Temperature	Yes	6	55
	No	104	94.5
Sleeping patterns	Yes	9	8.2
	No	101	91.8
Baby crying	Yes	7	6.4
	No	103	93.6
Immunisations	Yes	32	29.1
	No	78	70.9
Breast Feeding	Yes	32	30.9
	No	78	69.1

The above table shows that more than half of the respondents reported not being given information related to baby care. Of the 64 (58.2%) respondents who were not given information in relation to cord care, 18 (28.1%) were primiparae. Of the 94 (85.4%) respondents who were not given information regarding buttock care, 30 (31.9%) were

primiparae. The researcher's findings further show that 78 (70.9%) of the respondents were discharged without information in relation to baby bathing. Of these, 25 (32.1%) were primiparae. The findings of this study reveal that primiparae were discharged without information in relation to baby care. Smith (1989) emphasized that primiparae should receive additional assistance and support in areas of baby care.

The above findings imply that the teaching of mothers in the postnatal ward is still carried out somewhat haphazardly, and some first time mothers return home having received no instruction in most aspects of infant care. Beger and Cook (1998) recommend that as a result of shortened postpartum stays, it is necessary to identify and prioritise maternal learning needs and to develop effective and efficient educational programs.

Teaching is an inherent facet in the concept of selfcare. It is often assumed that the midwife will carry out this function, irrespective of the preparation she herself has received. It is routinely the task of the nurse to educate the mothers about baby care. According to Laryea (1984), lack of information may lead to frustration and feelings of helplessness and may increase dependency on others. Midwives should be aware that the purpose of giving information to the mother is to enable her to gain knowledge and understanding of mothering skills, so that she will be able to carry out these tasks independently. In this study, the majority of the respondents who were discharged home, relied on their family members for help and assistance.

4.2.1.9 Were you given information on the following in relation to yourself?

Table 4.10: Distribution of respondents who were given information in relation to self care (n = 110)

		FREQUENCY	PERCENT
Breast care/ Nipple care	Yes	22	20
	No	88	80
Breast engorgement	Yes	8	7.3
	No	102	92.7
After birth pains	Yes	8	7.3
	No	102	92.7
Perineal care	Yes	49	44.5
	No	61	55.5
Lochia/bleeding	Yes	12	10.9
	No	98	89.1
Postnatal exercises	Yes	9	8.2
	No	101	91.8
Perineal exercises	Yes	3	2.7
	No	107	97.3
Leg pains	Yes	3	2.7
	No	107	97.3
Family planning	Yes	32	29.1
	No	78	70.9
Diet	Yes	14	12.7
	No	96	87.3
Other		0	0

"Other" in this study means that no additional information was given.

It is evident from the above table that the majority of the respondents were not given information in relation to self. This is supported by Brown and Johnson's (1998) findings that knowledge deficit related to infant or selfcare was an appropriate diagnosis for 97%

of the participants in their project group. The majority of the women were uncertain about how to care for themselves.

The following aspects of postnatal care, while not necessarily life threatening, may play a significant role in a woman's health and are therefore subjected to further analysis.

* **Breast care:** Eighty-eight (80%) of women were not given information on how to care for their breasts This number constituted 28 (77.8%) primip and 60 (81.1%) multiparae.
* **Breast engorgement:** The table further reveals that 102 (92.7%) of mothers were not given information on breast engorgement. Of this number 34 (94.4%) were primiparas. This is a painful and uncomfortable condition and may influence a woman's decision to continue breastfeeding.
* **Perineal care:** The above findings show that 61 (55%) of the respondents who were not given information in relation to perineal care, six were primiparae. Perineal care is important in preventing infection to which the postpartum woman is particularly vulnerable.
* **Bleeding/Lochia:** In relation to lochia/bleeding, 98 (89.1%) were not given information. Of these, 32 (88.9%) were primiparae. Postpartum bleeding accounts for maternal mortality (25%) in child bearing women (Safemotherhood, 1998). It is essential that women are taught what is normal and what they can expect.

* **Leg pains:** One hundred and seven (97.3%) were discharged without information in relation to leg pains after delivery. This number constituted 34 (94.6%) primiparae and 72 (97.3%) multiparae.

* **Family planning:** In relation to family planning, 78 (70.9%) were not given information. Of this number 25 (69.4%) were primiparae and 54 (73%) were multiparae. Thus it would appear that women are not being empowered to take control of their futures.

Fishbein and Burggraf's (1998) findings suggest that additional education by nurses in hospital about perineal care is needed. Perineal care is needed to prevent infection and promote healing especially in mothers with episiotomies.

Beger and Cook (1998) further support the above statement by stating that mothers and nurses were in agreement that post-partum topics are of importance. For example, post-partum complications and stitches/episiotomy.

Findings reveal that almost all the respondents' informational needs were not met in the researcher's study regardless of parity. Beger and Cook (1998) conclude by stating that the individual learning needs of different groups of mothers needs to be accommodated when possible.

4.2.1.10 Would you like nurses to visit you at home after discharge?

Table 4.11: Distribution of respondents who would like to be visited at home after discharge (n = 110)

NURSE TO VISIT	FREQUENCY	PERCENT
Yes	109	99.1
No	1	0.9
TOTAL	110	100.0

The results reveal that almost all (99.1%) of the respondents stated that they wanted nurses to visit them at home after discharge.

Reasons why this would be liked were:

- to check whether they were encountering any problems in relation to care of the baby and self, and
- to teach them important aspects in relation to the care of baby and self.

Discharge home can be viewed as one stage in the continuum of maternity care. Postnatal care should not end when the mother leaves the hospital, but it should be continued in the community. Brown, Towne and York (1996) state that postpartum teaching can be done during a home visit, reinforcing information given in the hospital or birthing centre.

4.2.1.11 When would you have liked to be visited by midwives after discharge?

Table 4.12: Distribution of respondents who would like to be visited by midwives after discharge (n = 110)

WHEN MIDWIVES VISIT WITHIN:	FREQUENCY	PERCENT
3 days	81	73.7
7 days	24	21.8
>7 days	1	0.9
Other	4	3.6
TOTAL	**110**	**100.0**

Other: in this study refers to those respondents who specified the time

The majority of the respondents, 81 (73.7%), wanted to be visited within 3 days after delivery. Of this number, 31 (38.3%) were primiparae, and 50 (61.70%) were multiparae. Williams and Cooper (1993) suggest that follow-up services, in which nurses visit new families in their homes within a few hours or days of discharge, can bridge the gap in health care that exists between early discharge and routine checkups.

4.2.1.12 Were you fetched from hospital after discharge?

Table 4.13: Distribution of women who were fetched from hospital after discharge (n = 110)

WERE YOU FETCHED?	FREQUENCY	PERCENT
Yes	78	70.9
No	32	29.1
TOTAL	**110**	**100.0**

The 32 (29.1%) who were not fetched stated that there was nobody at home to fetch them from the hospital. They further stated that the time of discharge was not specified to them by the midwives.

4.2.1.13: If yes, who fetched you?

Table 4.14: Distribution of those who fetched the respondents from hospital

(n = 78)

WHO FETCHED YOU?	FREQUENCY	PERCENT
Husband	6	7.7
Sister	26	33.3
Mother	33	42.3
Friend	2	2.6
Aunt	3	3.8
Other	8	10.3
TOTAL	**78**	**100.0**

"Other" In this study refers to those fetched by people not mentioned above.

Of the 78 (70.9%) respondents who were fetched from hospital two-thirds, 59 (75.6%), of the respondents were fetched by their sisters and mothers. This is important because these are the people who help/assist new mothers when they get home.

4.2.1.14: **Did you receive any assistance at home after delivery?**

Table 4.15: Distribution of respondents who received assistance at home after delivery (n = 110)

RECEIVED ANY ASSISTANCE	FREQUENCY	PERCENT
Yes	105	95.5
No	5	4.5
TOTAL	**110**	**100.0**

The majority of the respondents, 105 (95.5%) were assisted/helped at home after discharge. The five (4.5%) who were not helped were all multiparae. These women stated that they had no help because their relatives were at work. Brown, Towne and York (1996) found that almost all the women (97.8%) who were discharged home had some help at home during the first week after delivery.

4.2.1.15: **If yes, who helped?**

Table 4.16: Distribution of relatives who helped (n = 105)

WHO HELPED?	FREQUENCY	PERCENT
Husband	5	4.8
Sister	24	22.9
Mother	59	56.2
Aunt	8	7.6
Friend	0	0
Other	9	8.6
TOTAL	**105**	**100.0**

"Other" in this study refers to those who were helped by people not mentioned above and those who helped themselves.

More than two-thirds of the respondents were helped by their sisters and mothers. It would appear that women are dependent on other female members of the household for help and assistance.

4.2.1.16: What help did they give you?

Table 4.17: Distribution of the type of help given to the respondents (n = 105)

WHAT HELP	FREQUENCY	PERCENT
All specified items	104	99.0
Not all specified	1	1.0
TOTAL	**105**	**100.0**

In this study, women were also asked whether there were any tasks with which they received help which were not listed in the schedule. None of the respondents had received help in any additional area. However, five (5) women stated that they had not received help with any of the tasks mentioned.

With reference to table 4.17 "all specified items" referred to these five activities:

- Dish washing
- Baby sitting

4.2.1.18: Did you experience any stressful events post-delivery?

Table 4.19: Distribution of respondents who experienced stressful events post-delivery (n = 110)

		FREQUENCY	PERCENT
Tearfulness	Yes	19	17.3
	No	91	82.7
Sleeping problems	Yes	13	11.8
	No	97	88.2
Rejection of baby	Yes	8	7.3
by sibling	No	102	92.7
Lack of assistance	Yes	18	16.4
from partner	No	92	83.6
Lack of assistance	Yes	9	8.2
from family	No	101	91.8
Financial problems	Yes	10	9.1
	No	100	90.9
Marital problems	Yes	1	0.9
	No	14	12.7
Single/Not applicable		95	86.4
Serious illness in	Yes	2	1.8
the family	No	108	98.2

Of the 19 (17.3%) respondents who experienced tearfulness, 12 (63.2%) were primiparae. The findings further reveal that 13 (11.8%) had sleeping problems, of this number, 9 (69.2%) were primiparae. Of the 18 (16.4%) who were not assisted by their partners, 14 (77.8%) were primiparae. Of the 10 (9.1%) who experienced financial problems, all were primiparae.

Some women experience tearfulness 3-4 days following delivery. It is usually viewed as a normal sequel of childbirth, apparently transient and self-limiting in nature, and the

mother recovers without treatment after a few days. The role of the midwife in relation to stressful events, is to be understanding and supportive to the mother. According to Laryea (1984) weeping may also be part of the grieving process over the loss of freedom, since the new mother now realises that there is no turning back. Therefore, midwives should be aware that giving information prior to childbirth helps the individual to cope better with the situation. For the majority of mothers, this may be the ideal opportunity for them to learn about the changes.

An attempt was made to determine whether age and/or parity were significant in relation to the findings. However, bivariate analysis did not reveal any significant relationships.

4.3 CONCLUSION

In this chapter the findings from the 110 interviews conducted with postpartum women have been described. Seventy-four multiparae and 36 primiparae were interviewed. Reasons for early discharge varied. The results revealed that women were discharged without information in relation to baby and self. Those who wanted to be discharged early felt it was appropriate to be cared for by their relatives. The respondents who were not ready to go home, gave reasons that they had painful stitches and that they did not know how to bath and take care of their newborn babies. Almost all (99.1%) of the respondents wanted to be visited by nurses at home after discharge. Almost all respondents (98.2%) wanted to be given hospital phone numbers on discharge.

CHAPTER 5

In this chapter the summary, limitations of the study and recommendations will be discussed.

5.1 SUMMARY

The purpose of this study was to investigate women's perceptions of early discharge after childbirth and to determine their needs.

The study was conducted in Francistown, Botswana. A descriptive survey design was undertaken in order to study the views of postpartum mothers in relation to early postpartum discharge. The number of postpartum women interviewed was 110. The sample consisted of both multiparae and primiparae, between the ages of 18-49 years and who had had normal vaginal deliveries. An interview schedule was used to obtain information from postpartum mothers. Data was collected over a period of three weeks.

5.1.1 Objectives

The objectives of this study were to:

- determine the perceptions of postpartum women in relation to early postpartum discharge,
- identify problems experienced with early postpartum discharge.

5.1.2 Summary of Findings

The findings of the study revealed that respondents felt that it was good to be discharged early in order to join their families back home for support. The majority of respondents indicated readiness for discharge and not needing more time in hospital (69.1% and 63.6% respectively). Those respondents who felt it was not good, felt they lacked information and basic skills in relation to care of their babies and self. The findings further revealed that the respondents would like to be visited at home within three days post-delivery. Respondents also felt it was important for them to be given a hospital phone number in order to be able to contact nurses when they had problems. The findings revealed a variety of problems in relation to early postpartum discharge, for example, lack of care and information given in hospital. Though it is routinely the task of the midwife to educate the postpartum woman after delivery about self care and care of the newborn baby at home, it was found that there was a high negative response rate in relation to the information given.

5.2 LIMITATIONS

- Research was conducted in only one urban setting, therefore findings cannot be generalised beyond the sample.
- The findings of this research are limited to the five clinics.
- The questionnaire was formulated in English and translated to Setswana, some meaningful ideas may be lost.

5.3 RECOMMENDATIONS

The following recommendations can be made:

5.3.1 For Nursing Practice:

- Each postnatal ward should have a teaching manual which gives instructions or information that must be given, so that the midwife knows what information to give to the mothers.
- Midwives should always evaluate information given to the mothers. They should get feedback from the mothers. It enables the midwife to identify areas where the mother may have failed to understand, or misinterpreted the information.

- Midwives should explore other methods of teaching, for example, poster presentation, so that she is in a position to cater for the differences in ability of the mothers she is teaching.
- The needs of mothers must be recognised, so that information given is individualised. This means that the difference in levels of competence of the mothers and their abilities should be taken into account.
- Midwives require communication skills to enable them to impart individualised knowledge. If knowledge is individualised, it will be meaningful and appropriate.
- Topics related to personal care, for example, perineal care and care of the breast should be incorporated into health education, particularly for single and first time mothers. They should be given pamphlets for reference.
- Women should be given hospital phone numbers on discharge so that they can contact the nurse when they encounter problems at home.

5.3.2 For Further Nursing Research:

- A similar research study should be undertaken to cover the whole country so that the results could be generalised and determine the extent of the problem so that a national policy for care of postpartum mothers can be standardised.
- A similar study should be undertaken to establish the views of midwives in relation to early postpartum discharge.

- Midwives should explore other methods of teaching, for example, poster presentation, so that she is in a position to cater for the differences in ability of the mothers she is teaching.
- The needs of mothers must be recognised, so that information given is individualised. This means that the difference in levels of competence of the mothers and their abilities should be taken into account.
- Midwives require communication skills to enable them to impart individualised knowledge. If knowledge is individualised, it will be meaningful and appropriate.
- Topics related to personal care, for example, perineal care and care of the breast should be incorporated into health education, particularly for single and first time mothers. They should be given pamphlets for reference.
- Women should be given hospital phone numbers on discharge so that they can contact the nurse when they encounter problems at home.

5.3.2 For Further Nursing Research:

- A similar research study should be undertaken to cover the whole country so that the results could be generalised and determine the extent of the problem so that a national policy for care of postpartum mothers can be standardised.
- A similar study should be undertaken to establish the views of midwives in relation to early postpartum discharge.

- A similar study should be conducted on teenage mothers to identify the problems of groups with special needs.
- A similar study should be done on mothers who have experienced delivery problems in order that their specific needs can be identified.

5.3.3 Nursing Education

- Schools of nursing or institutions of health sciences should incorporate aspects of early postpartum discharge into their curriculae, for example, information giving for discharge planning. Mothers have been found not to be able to absorb large amounts of information at once. Thus methods of health education must be addressed in the curriculae.

5.4 CONCLUSION

The objectives of the study were:

- To determine the perceptions of postpartum women in relation to early postpartum discharge.
- To identify problems experienced with early postpartum discharge.

The above objectives were met. One hundred and ten women between the ages of 18-49 years were interviewed. The findings show that perceptions of postpartum women in relation to early postpartum discharge were wide ranging. The findings further revealed

that an element of care is lacking, but that they do not mind being discharged early. The findings show that they are assisted by their mothers and sisters and require information on self and baby care before discharge. They also would like to be visited by midwives at home within three days post-discharge.

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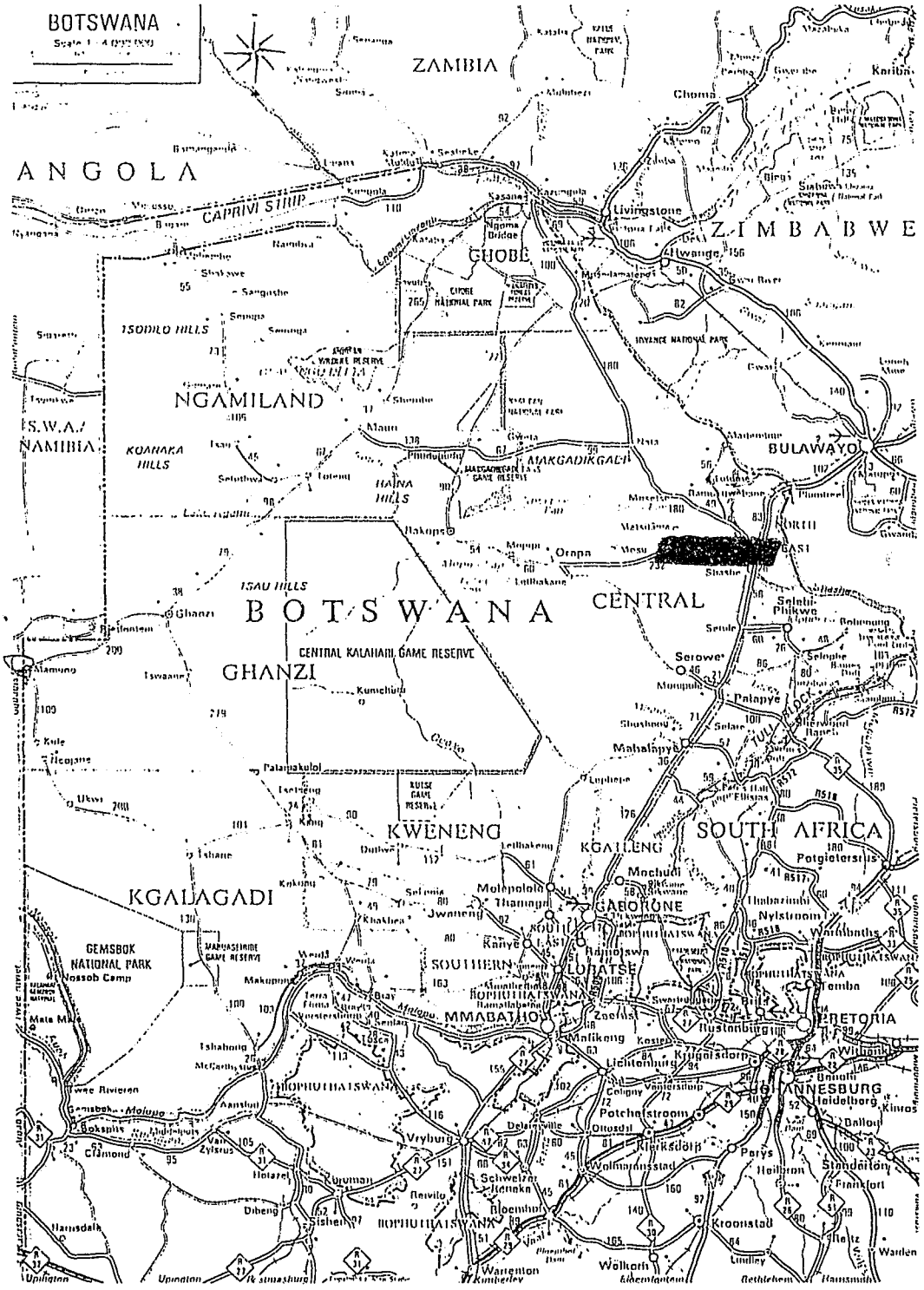
ANNEXURE A

BOTSWANA


BOTSWANA
ZAMBIA
ANGOLA
ZIMBABWE
NAMIBIA
S.W.A./
CAPRIVI STRIP
CHOBE
NGAMILAND
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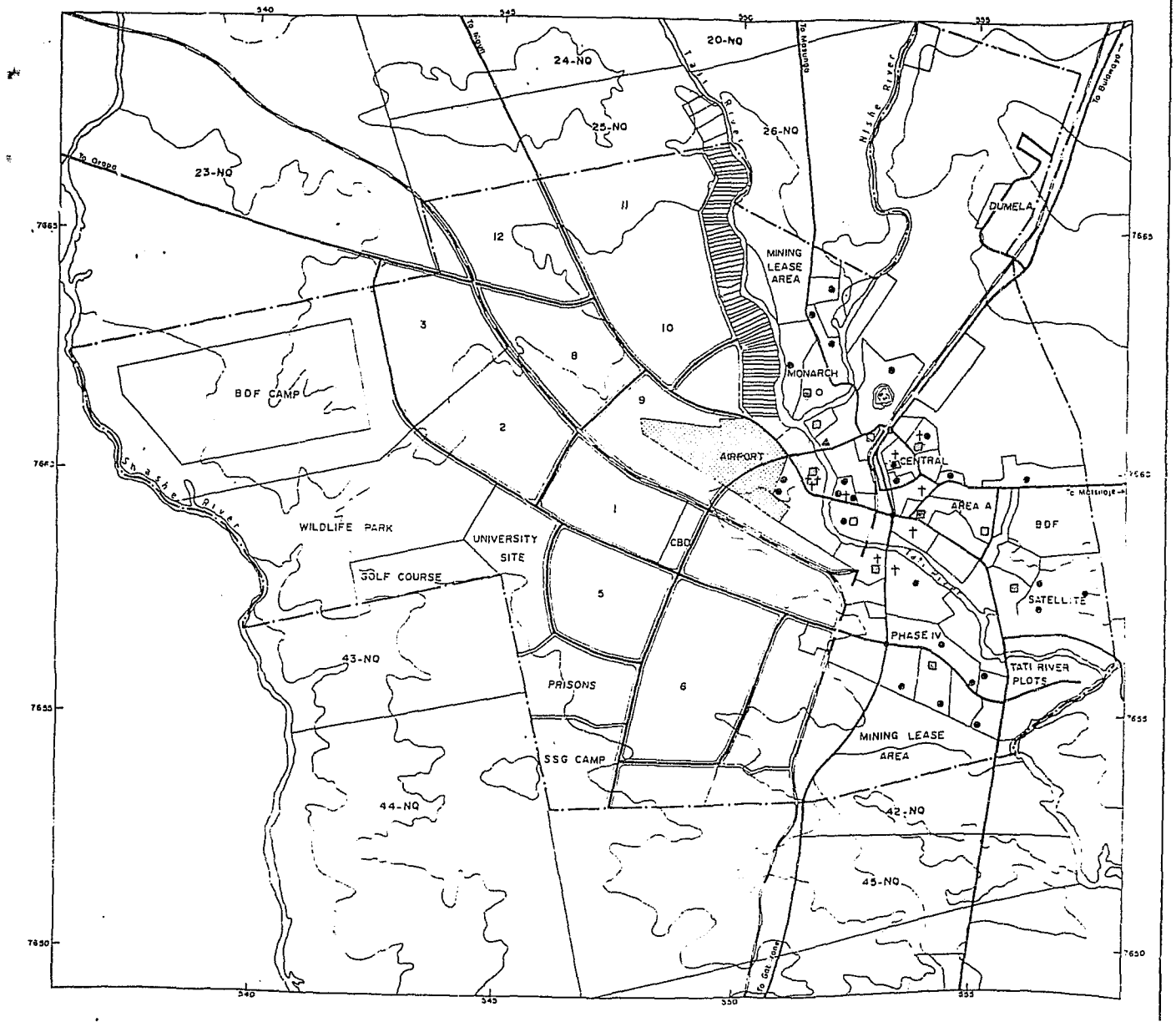
KOANAKA HILLS
HAINA HILLS
MAKGADIKGADI
BULAWAYO
NORTH EAST
BOTSWANA CENTRAL
ISAU HILLS
CENTRAL KALAHARI GAME RESERVE
GHANZI
KWENENG
KGATLENG
SOUTH AFRICA
KGALAGADI
GEMSBOK NATIONAL PARK
SOUTHERN
GABORONE
MMABATHO
PRETORIA
JOHANNESBURG
FULL BLOCK
Francistown
Livingstone
Kasane
Maun
Orapa
Lethakane
Serowe
Palapye
Mahalapye
Selebi-Phikwe
Molepolole
Kanye
Jwaneng
Lobatse
Potchefstroom
Klerksdorp
Vryburg
Kuruman
Upington
Kimberley
Warrenton
Wolmaransstad
Kroonstad
Bloemhof
Schweizer-Reneke
Zeerust
Mafikeng
Lichtenburg
Rustenburg
Brits
Hartbeespoort
Nylstroom
Warmbaths
Potgietersrus
Louis Trichardt
Messina
Polokwane
Tzaneen
Phalaborwa
Hoedspruit
Nelspruit
Witbank
Middelburg
Ermelo
Standerton
Heidelberg
Vereeniging
Vanderbijlpark
Sasolburg
Parys
Frankfort
Heilbron
Bethlehem
Harrismith
Ficksburg
Senekal
Winburg
Virginia
Welkom
Odendaalsrus
Hennenman
Theunissen
Boshof
Hopetown
Prieska
Douglas
Postmasburg
Kuruman
Hotazel
Kathu
Upington
Keimoes
Kakamas
Pofadder
Springbok
Garies
Kamieskroon
Vanrhynsdorp
Clanwilliam
Citrusdal
Piketberg
Malmesbury
Paarl
Stellenbosch
Somerset West
Caledon
Bredasdorp
Swellendam
Riversdale
Mossel Bay
George
Knysna
Plettenberg Bay
Humansdorp
Port Elizabeth
Uitenhage
Grahamstown
Cradock
Graaff-Reinet
Middelburg
Cookhouse
Somerset East
Aliwal North
Barkly East
Rhodes
Lady Grey
Sterkspruit
Zastron
Wepener
Ladybrand
Clocolan
Ficksburg
Harrismith
Bethlehem
Reitz
Frankfort
Standerton
Balfour
Delmas
Bronkhorstspruit
Cullinan
Hammanskraal
Soutpansberg
Thohoyandou
Sibasa
Louis Trichardt
Pietersburg
Potgietersrus
Warmbaths
Nylstroom
Brits
Rustenburg
Krugersdorp
Randfontein
Westonaria
Carletonville
Potchefstroom
Ventersdorp
Lichtenburg
Zeerust
Mafikeng
Vryburg
Taung
Kuruman
Hotazel
Kathu
Postmasburg
Griquastad
Douglas
Prieska
Hopetown
Colesberg
Noupoort
Middelburg
Cradock
Graaff-Reinet
Aberdeen
Willowmore
Steytlerville
Jansenville
Uitenhage
Port Elizabeth
Humansdorp
Knysna
George
Mossel Bay
Riversdale
Swellendam
Caledon
Somerset West
Stellenbosch
Paarl
Malmesbury
Moorreesburg
Piketberg
Citrusdal
Clanwilliam
Vanrhynsdorp
Kamieskroon
Garies
Springbok
Pofadder
Kakamas
Keimoes
Upington
Kimberley
Warrenton

ANNEXURE B

MAP 6

CITY OF FRANCISTOWN DEVELOPMENT PLAN

EXISTING CIVIC AND COMMUNITY FACILITIES



ANNEXURE C

INTERVIEW GUIDE

SECTION 1
DEMOGRAPHIC DATA AND BACKGROUND

1. **Age in Years**
   - 18 - 21 ☐
   - 22 - 25 ☐
   - 26 - 29 ☐
   - 30 - 33 ☐
   - 34 - 37 ☐
   - 38 - 41 ☐
   - 42 - 45 ☐
   - 46 - 49 ☐

2. **Marital Status:**
   - Single ☐
   - Married ☐
   - Widowed ☐
   - Separated ☐
   - Divorced ☐

3. **How many children do you have?:** ☐

4. **Your highest educational qualifications:**
   - Primary ☐
   - Secondary ☐
   - Junior Certificate ☐
   - Cambridge ☐
   - Postgraduate ☐
   - Other (specify) ☐

5. **Are you working?**
   - Yes ☐
   - No ☐

6. **If yes, are you in permanent or temporary employment:**

Permanent ☐

Temporary ☐

SECTION 2

PERCEPTIONS:

1. **When were you discharged from hospital after delivery?**

6 hours ☐

7-10 hours ☐

11-15 hours ☐

16-20 hours ☐

21-24 hours ☐

2. **Did you feel ready to leave hospital at this time?**

Yes ☐

No ☐

Please explain: _____

_____

3. **Is it good to be discharged early?**

Yes ☐

No ☐

Please explain: _____

_____

4. **Do you think you needed more time in hospital?**

Yes ☐

No ☐

Please explain: _____

_____

5. **When would you have liked to be discharged?**

6 hours ☐
>24 hours ☐
>72 hours ☐
3 days ☐
7 days ☐
Other (Specify) ☐

6. **Were you happy with when you were discharged?**

Yes ☐
No ☐
Please explain: _____

_____

7. **Did you experience any problems at home after discharge?**

Yes ☐
No ☐
Please explain: _____

_____

8. **Were you given information on the following in relation to your baby?**

		Yes	No
i)	Eye care		
ii)	Cord care		
iii)	Buttock care		
iv)	Skin care/colour of skin		
v)	Care of nappies		
vi)	Baby bathing/hygiene		
vii)	Temperature		
viii)	Sleeping patterns		
ix)	Baby crying		
x)	Immunisations		

		Yes	No
xi)	Breastfeeding		

xii) Other (specify) _____

9. Were you given information on the following in relation to yourself?

		Yes	No
i)	Breast care/nipple care		
ii)	Breast engorgement		
iii)	Afterbirth pains		
iv)	Perineal care		
v)	Lochia/bleeding		
vi)	Postnatal exercises		
vii)	Perineal exercises		
viii)	Leg pains		
ix)	Family planning		
x)	Diet		

xi) Other (specifiy) _____

10. Would you like nurses to visit you at home after discharge?

Yes ☐

No ☐

Please explain: _____

_____

11. When would you like to be visited by midwives after discharge?

3 days ☐

7 days ☐

>7 days ☐

Other (specify) _____

12. **Were you fetched from hospital after discharge?**

Yes ☐

No ☐

If no, why?: _____

_____

13. **If Yes, who fetched you?**

Husband ☐

Sister ☐

Mother ☐

Friend ☐

Aunt ☐

Other (specify): _____

_____

14. **Did you receive any assistance at home after discharge?**

Yes ☐

No ☐

If no, why?: _____

_____

If yes, who helped?

Husband ☐

Sister ☐

Mother ☐

Friend ☐

Aunt ☐

Other (specify): _____

_____

15. **What help did they give you?**

Dish washing ☐
Baby sitting ☐
Cooking ☐
House cleaning ☐
Shopping ☐
Other (specify): _____

_____

16. **Would you like to be given hospital phone numbers on discharge?**

Yes ☐
No ☐
If yes, why? Please specify: _____

_____

17. **Did you experience any stressful events post-delivery?**

		Yes	No
i)	Tearfulness		
ii)	Sleeping problems		
iii)	Rejection of baby by sibling		
iv)	Lack of assistance from partner		
v)	Lack of assistance from family		
vi)	Financial problems		
vii)	Marital problems		
viii)	Serious illness in family		
xi)	Other (please specify:		

_____

_____

ANNEXURE D

INFORMATION LETTER

My name is Ogar Rapinyana. I am a second year Masters student of the University of the Witwatersrand. I am expected to conduct a research study in partial fulfilment of the programme. The purpose of my study is to investigate women's experience of early discharge after childbirth.

This study is aiming to create an awareness that could lead to improve service and meet the needs of postnatal women. I therefore request you to be one of my participants. Your participation will not affect the type of health care that you will receive after participation. What you say will not be used against you. You only participate if you choose to do so. You can also withdraw from participation at any time. The interview will take 15-20 minutes. Your name will not appear on the interview guide. Information will be confidential.

ANNEXURE E

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Rapinyana

CLEARANCE CERTIFICATE PROTOCOL NUMBER M980543

PROJECT Postpartum Womens Perception of Early Discharge From Hospital Six Weeks Postpartum

INVESTIGATORS Mrs O Rapinyana

DEPARTMENT Dept of Nursing Education, Ministry of Health Bostwana

DATE CONSIDERED 980529

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 980617 CHAIRMAN .....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Miss P McInerney
Dept of Dept of Nursing Education, Wits University

Works2\lain0015\HumEth97.wdb\M 980543

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DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE 23/6/98 SIGNATURE .....

PROTOCOL NO.: M 980543

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE F

FRANCISTOWN CITY COUNCIL

FRANCISTOWN

ALL CORRESPONDENCE TO BE ADDRESSED TO THE TOWN CLERK

PRIVATE BAG 40 FRANCISTOWN BOTSWANA

TELEPHONE: (267) 211050 FAX: (267) 212427

REF: FCC/47

22rd April 1998

Ogar Rapinyane
University of Witwatersrand
House No. F8, Parktown
University of the Witwatersrand
Parktown 2050
JOHANNESBURG

Dear Sir

RE: GRANT OF A RESEARCH PERMIT - YOURSELF

Your request for a research permit refers.

We are pleased to inform you that you have been granted permission to conduct research that "Aims to improve service and meet the needs of Post Natal Women.

Although permission is granted, you will be expected to fulfil the following conditions:-

1. Make a stop briefly at the Health Dept. Head Quarters to introduce yourself before the start of the project.

2. Work in close liason with both the Council Health Managers and the Senior Nursing Sisters incharge of catchment areas.

3. Copies of papers written as a result of the stud should be made available to this Council for use in future planning, expansion and improvement of health services.

Looking forward to seeing you.

Yours faithfully

K. Kebabonye
for/City Clerk

Parktown Village 1
House No F8, Parktown
University of the Witwatersrand
Parktown 2050
Johannesburg

30.03.1998

The City Clerk
Francistown City Council
Private Bag 40
Francistown
BOTSWANA

Attention: City Matron

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH

I am a second year Masters student at the University of the Witwatersrand. I am conducting a research study as part of the fulfilment of my program study. I therefore write to seek permission to conduct my study in the city clinics. Patients will be asked to voluntarily participate in an interview which will last for 15-20 minutes. This study aims to create an awareness that could lead to improved service and meet the needs of postnatal women. I intend to carry out the research during the month of July, 1998. My target group is all postnatal women six weeks after delivery.

Thanking you in advance

Yours faithfully

OGAR RAPINYANA (Mrs)

Author Rapinyana O
Name of thesis Postpartum Women'S Perception Of Early Discharge From Hospital Rapinyana O 1999

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