

Stage III



Educational Modules for Physical Postpartum Health Associated with Vaginal Deliveries

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Abstract

Epidemiological studies have concluded that a great deal of women experience some type of physical health issue eight weeks to a year post childbirth (Herron-Marx, Williams, and Hicks, 2005). Research illustrates that it is necessary that postpartum women receive adequate care and knowledge regarding managing the various morbidities that occur during this period. Proposed is a program that is composed of five educational modules to address the third stage of pregnancy, the postpartum period. *Stage III*, intends to address this issue while providing intensive education about the physical issues and health morbidities that occur during the postpartum period. Additionally, *Stage III* intends to increase the awareness of postpartum health among primiparous women, with a subpopulation consisting of adolescent and teenage primiparas.

Problem Statement

The puerperium is thought to have ended six weeks postpartum, however, for many women, some morbidity still persist. More importantly, there is some evidence indicative to the fact that various postpartum morbidities are more common, and of longer intervals among women who have experienced caesarean or assisted vaginal deliveries (Lyndon-Rochelle, Holt, & Martin, 2001). More specifically, it is estimated that 87% of women experience at least one physical health issue eight weeks following childbirth, while 76% of women report that the issue persists 12-18 months postpartum (Herron-Marx, Williams, and Hicks, 2005). This gap of education and care not only affects older primiparas, but adolescents and teenage primiparas as well. However, the health care provided to postpartum women is contradictory to the aforementioned evidence. There is one standard postnatal visit following delivery, which occurs at the six week period. Physicians, nurses, and midwives have a responsibility to inform women about the most common physical challenges that lie ahead in the postpartum period (Borders, 2006). The information should be shared prior to birth, and again postpartum (p. 246). Women who are prepared for the postpartum period are more likely to appropriately manage their self care (p. 246).

Commonly the outlook towards pregnancy surrounds the preparation for childbirth, as well as, the health and well being of the infant. Months prior to delivery include frequent intense prenatal care, however, once delivery is accomplished the mother's postpartum physical health is fundamentally disregarded (Borders, 2006). Most first time mothers (primiparas) are unaware of the physical care that is required during the postpartum period. The postpartum period is defined as the interval following childbirth that is required for the reproductive organs to return to their nonpregnant state (Gjerdigen, Froberg, Chaloner, and McGovern, 1993).

Various short term and long term epidemiological studies have been conducted, emphasizing high levels of morbidity in women following childbirth (Herron-Marx, Williams, and Hicks, 2005). Statistically, 87% of women experience at least one health dilemma eight weeks following childbirth, while 76% continue to experience some type of health problem 12-18 months postpartum (p. 323). However, following childbirth there is a standard six week postnatal visit, and this visit is the final routine postnatal assessment (Lydon-Rochelle, Holt, & Martin, 2001). More importantly, this check up marks the conclusion of the perineum based on the postulation that physical recovery is complete (p. 232). The postpartum period or puerperium is a significant time in women's lives, because it involves various major physiological changes (Gruis, 1977). Besides the reproductive organs returning to their normal state, the organs which shifted due to the enlarged uterus take up their normal position (p. 183). Additionally, the abdominal wall stretched to make room for the growing uterus, and will remain soft and flaccid for weeks following the delivery (p. 183). The cervix will contract to an almost closed pre-pregnant state while the vagina decreases in size gradually (p. 183).

Not only is the postpartum period a time of physical change, it is a time of physical discomfort. The most common sources of discomfort and concern for the women include:

incontinence, lochia flow, care of perineum, and hemorrhoids (Gjerdigen, Froberg, Chaloner, and McGovern, 1993). A vast majority of women report urinary incontinence during pregnancy or following childbirth (Thomason, Miller, and DeLancey, 2006). Incontinence is the involuntary loss of urine, and is common pre and postpartum (NIH, 2007). There are various forms of urinary incontinence which include: stress, urge, overactive bladder, functional, overflow, mixed, and transient (p. 4). However, stress incontinence is the most common type of incontinence experienced by women during and after pregnancy (p. 2). The physical changes that the body undergoes during pregnancy, as well as, the stress put on the bladder causes stress incontinence (p. 2). Actions such as sneezing, coughing, laughing or other movements that put pressure on the bladder cause the loss of urine, and are typical signs of stress incontinence (p. 2). Thomason and colleagues' study report that 51% of primiparas experienced incontinence both during and after pregnancy. For the most part, stress incontinence usually resolves as the body heals during the postpartum period; however research shows the condition can persist as long as 12 months post labor (Thomason, Miller, and DeLancey, 2006). Many women find that stress incontinence affects their daily lives and can become an inconvenience (Herron-Marx, Williams, and Hicks, 2005). The research also revealed that many women do not seek help for incontinence, because the issue seems minor as well as embarrassing (p. 323).

In addition to urinary incontinence, some women may experience fecal incontinence. Fecal incontinence is the inability to control bowel movements or flatulence (MayoClinic, 2008). This type of incontinence varies from an infrequent leakage of stool during flatus to a complete loss of bowel control (p. 1). One may experience fecal incontinence if an injury to the muscles or nerves of the anal sphincter occurred during childbirth (p. 1). Stool and flatus incontinence are frequent complications of childbirth (Eason, Labrecque, Marcoux, & Mondor, 2002). According

to Eason and colleagues, “anal incontinence post childbirth is more common than previously believed.” The study asserts that reports of incontinence among primiparous women ranges from 2% to 6%, and incontinence of stool or flatus from 13% to 25% (p. 326). Borders (2006), affirms that births accomplished with the use of forceps doubled the woman’s risk of developing fecal incontinence within three months. Additionally, the percentage increases if there are severe lacerations of the perineum (p. 326). Another potential problem for new mothers is avoiding bowel movements (MayoClinic, 2008). Primiparas avoid bowel movements in fear of the pain it will cause to the perineum, episiotomy wound, and hemorrhoids (p. 1).

Bleeding and vaginal discharge following childbirth is referred to as lochia (MayoClinic, 2008). The discharge or bleeding is a combination of old uterine lining and blood, and can persist for up to six weeks post childbirth (p. 1). Initially, the lochia will be bright red, and accompanied by a heavy flow (p. 1). As the weeks progress it will gradually peter out, changing from pink to whitish in color (p. 1). Furthermore, it is not uncommon for the bleeding to start and stop or to contain clots (p.1). The morbidity issue of great concern during the lochia period is infection. A common mistake among first time mothers during this period is the use of tampons to manage the bleeding. Women should not use tampons for at least six weeks postpartum (American College of Obstetricians and Gynecologists, 2007). There is a wound at the site where the placenta attached to the uterine wall, and the use of tampons can introduce bacteria into the healing uterus causing an infection (p. 1).

Infection is not solely a risk during the lochia phase; it remains a risk while the perineum begins to heal. In order to decrease the risk of infection, it is important that nothing is introduced into the vaginal cavity as it heals. In addition to the risk of infection caused by tampon usage, studies have reported cases of nonmenstrual toxic shock syndrome (TSS) in association with the

use of barrier contraceptives during the postpartum period (Andrews, Parent, Barry, & Parsonnet, 2001). What is more important, douching should be avoided in the early postpartum weeks as there is a threat of introducing infection (Kuczynski, 1980). Postpartum women should wait to douche after the six weeks postnatal visit, in order to determine the extent of involution and healing of the reproductive system (p. 91). Also, in previous years physicians advised couples to abstain from intercourse for six weeks after childbirth to prevent infection (Inglis, 1980).

Not only does intercourse carry a risk of infection during the postpartum period, it can be yet another source of physical discomfort. Perineal pain and dyspareunia are common experiences for women following childbirth (Barrett, Pendry, Peacock, Victor, Thakar, & Manyonda, 2000). Dyspareunia is simply defined as abnormal pain during intercourse (MayoClinic, 2008). Multiple studies have concluded that dyspareunia is associated with episiotomies or assisted vaginal births (Barrett et. al., 2000 and Gjerdingen et. al., 1993). Barrett and colleagues assert that parity is significant, because primiparous women have higher rates of episiotomies and assisted vaginal deliveries, thus reporting higher levels of dyspareunia and perineal pain.

Another discomfort and concern is the care of the perineum. The perineum is the area between the vagina and rectum (MayoClinic, 2008). Much stress is put on this area during vaginal delivery from the force of pushing, or from the episiotomy (p. 1). An episiotomy is a frequently used obstetrical procedure, and is defined as an incision made in the tissue between the vaginal opening and perineum (MayoClinic, 2008). This procedure is seen as a preventative measure to avert more extensive vaginal tears during childbirth (p. 1). Stitches from the episiotomy will dissolve in the subsequent weeks following childbirth (p. 1). Care of the episiotomy involves keeping the area clean, as well as, pain management for the mother (p. 1).

Cleanliness is the most important factor when caring for the perineum. Keeping the area clean promotes comfort, healing, and prevents the opportunity for infections (p. 1). The use of a sitz bath or peri-bottle will assist in keeping the area clean (p. 1).

A further discomfort experienced by most women during and after pregnancy is hemorrhoids (MayoClinic, 2008). Hemorrhoids are varicose veins of the rectum caused by the weight and pressure of the baby, as well as, the force of pushing (p. 2). As the body heals during the postpartum period, the hemorrhoids will decrease in size and become less painful (p. 2). The same type of care as discussed with the perineum can be utilized to care for hemorrhoids. For additional comfort, women may find sitting in the sitz bath helpful, or may apply pads with witch hazel (p. 2).

Another physical postpartum concern is breast engorgement (Borders, 2006). Regardless of the choice to breastfeed or not, breast engorgement affects lactating women for the first two weeks following delivery (Hill and Humenick, 1994). Breast engorgement is the uncomfortable and sometimes painful overfilling of the breast with milk (p. 79). The engorgement begins with retention of milk in the alveoli, leading to expansion and compression of surrounding milk ducts (p. 79). Primiparas frequently suffer more from engorgement than multiparas; due to the time it takes for mature milk to be produced (Breastfeeding, 2008). For women who choose to breastfeed, the swelling may impede the infant from latching onto the breast properly (Hill and Humenick, 1994). Thus, feeding is painful for the mother, and the collecting ducts are not emptied (p. 79). The research asserts that breast engorgement is most frequently reported on days three through five or days four through six (p. 80). It is suggested that frequent feeding or pumping will reduce the sensation of engorgement (Breastfeeding, 2008). Furthermore,

massaging the breasts, as well as, the use of a cold compact will reduce pain and swelling for the mother (p. 1).

There remain other concerns for primiparas and multiparas alike. Discussed were the most common physical issues that arise during the postpartum period. Primiparas require information to meet their awareness deficit regarding self care. Postpartum care is a crucial factor of maternity care, and requires as much attention as prenatal care. Typically, the six week postnatal visit following childbirth marks the end of the postpartum period (Lydon-Rochelle, Holt, and Martin, 2001). At this time it is assumed that the physical recovery is completed, however, many of the morbidity issues persist past six weeks (p. 232). For this reason, it is imperative that postpartum physical health be researched more extensively. What is more important is that there is paucity in the literature. The research failed to produce valuable information regarding how teenage primiparas are affected by physical postpartum changes. According to the Center for Disease Control and Prevention (2009), “in 2006, a total of 435,427 infants were born to mothers aged 15-19 years.” Giving birth during the adolescent years carries increased risk of obstetrical complications, and can be a health risk to the mother (Porterfield and Harris, 1986). Moreover, past studies purport that adolescents experience an increased incidence of postpartum infections (p. 40). It is of great importance that primiparas, both adolescents and non-adolescent, receive intensive education of postpartum health.

MODULE 1

Postpartum Health Education

Module 1:

Provide intensive education about postpartum health.

- Goal: To educate participants about physical health issues that occurs during the postpartum period.
 - Objective: By the module's end, the postpartum women will be able to recognize the physiological changes that occur postpartum.

MODULE 2

Methods of Self Care

Module 2:

Introduce methods of self care to postpartum women.

- Goal: Increase awareness of self care among primipara postpartum women.
 - Objective: By the module's end the postpartum women will be able to care for health issues that arise during this period such as: episiotomy stitches, hemorrhoids, and perineal pain.
 - Visual aid tools such as sitz baths and peri-bottles will be used to assist in educating the participants on self care techniques.

MODULE 3

Postpartum Vaginal Health

Module 3:

Discuss the importance of postpartum vaginal health.

- Goal: Decrease morbidity associated with the insertion of objects into the postpartum vagina.
 - Objective: Explain why infections occur when items such as tampons and barrier contraceptives are inserted into the postpartum vagina.
 - Visual aid tools such a model birth canal will assist in educating the participants by illustrating why and where the infection occurs.

MODULE 4

Postpartum Breast Health

Module 4:

How to manage postpartum breast health

- Goal: Increase the ability to manage postpartum breast engorgement.
 - Objective: By the module's end, the women will be able to identify breast engorgement.
 - Objective: Breastfeeding mothers will learn the fundamentals of breastfeeding.
 - Resources and information regarding how to access a lactation consultant will be provided.
 - Objective: Non-breastfeeding postpartum women will learn how to void the breast of milk.
 - Resources and information regarding how to access a lactation consultant will be provided.
 - Objective: Postpartum women will learn how to manage the pain of engorgement.

MODULE 5

Postpartum Intercourse

Module 5:

Address issues surrounding postpartum intercourse.

- Goal: Decrease morbidity issues that occur when intercourse is resumed during the postpartum period.
 - Objective: By the module's end, the participants will become aware of the risk of infection if she resumes intercourse before the vagina and perineum has healed.

Marketing Plan

Stage III will be marketed to primiparas, with a subpopulation consisting of adolescent and teenage primiparas. In order to capture the adolescent and non-adolescent primiparas, flyers and posters will be posted on bulletin boards at the health departments, Planned Parenthood offices, and WIC offices. Additionally, brochures summarizing the modules and goals of the program will be given to each individual at their prenatal checkups. The program will also be directly marketed to adolescent and teenage primiparas who have access to the Resource Mothers program located in Portsmouth, Virginia. Media sources such as Cosmo Girl and Seventeen Magazine will also serve as marketing tools for the adolescent and teenage population. It is important to target adolescent and non-adolescent primiparas alike; however, the need to target adolescents is greater, because the literature illustrates a gap in postpartum health regarding this group.

In order to capture a larger audience, *Stage III* will also be marketed in the health and fitness sections of magazines including but not limited to: Women's Health, Parenting, Motherhood, Self, Prevention, Ebony, Essence, Glamour, Cosmopolitan, Ladies Home Journal, and Marie Claire. More importantly, because it is the responsibility of physicians, nurses, and midwives to educate women about postpartum health *Stage III* will also be marketed to journals such as: Maternal-Child Nursing Journal, Journal of Midwifery and Women's Health, and American Journal of Obstetrics and Gynecology.

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After Pregnancy in Continent and Incontinent Primiparas. *International Urogynecology Journal*, (18) 2, 147-151.

Appendix A

Checklist Related to Postpartum Care

1. Perineal Care

- a. Keep the area clean with the use of a peri-bottle.
- b. To reduce pain from episiotomy stitched soak in sitz bath for 15 minutes, three times a day.
- c. To reduce pain from hemorrhoids soak in sitz bath, or apply witch hazel with a pad.

2. Lochia flow

- a. Use maternity or absorbent maxi pads.
 - i. Do not use tampons as there is risk for infection.
- b. Do not douche.
- c. Lochia flow will last for two to six weeks.
 - i. The flow may begin heavy and eventually lighten.
 - ii. Initially it will be bright red, then brownish/pink, and finally yellow/white.
 - iii. See your physician if flow is more than a heavy period or if a foul smell occurs. These are potential signs of infection.
 - iv. Change your pad each time you use the bathroom.

3. Episiotomy Stitches

- a. Keep the stitches clean with the use of a peri-bottle or sitz bath.
- b. Pat or wipe yourself dry from front to back to avoid introducing bacteria to the stitches.

4. Intercourse

- a. Refrain from intercourse six weeks after childbirth, and use of barrier contraceptives.
 - i. Both of these actions carry the risk of infection. Speak with your physician about an appropriate time to resume the use of barrier contraceptives and intercourse.

5. Breast Health

- a. Speak with a lactation consult to assist in breastfeeding or voiding the breasts.
- b. For pain and swelling use ice packs for a short period after nursing.

6. Incontinence

- a. Do not be afraid to defecate or urinate. Avoid constipation and urinary tract infections by drinking plenty of water, and eating fiber rich foods such as fruits and vegetables.
- b. Do Kegel exercised to strengthen your pelvic floor muscles.
- c. Speak with your physician if incontinence persists.

Appendix B

Postpartum Necessities



1. Sitz bath: Will assist with soothing perineal and hemorrhoid, as well as, maintain cleanliness.



2. Peri-bottle: Will assist in keeping perineum and episiotomy stitches clean.



3. Pads: Use pads to manage lochia flow, do not use tampons.