Do women who have encountered vaginal childbirth experience long term incontinence or perineal pain?

Abstract

It has been established that around 85% of women who have had a vaginal birth experience perineal trauma, of which approximately 70% of these will require suturing. In the 2011 UK census, 503 972 vaginal births were recorded and 370 984 women experienced perineal trauma. Women anecdotally reporting their concerns in future pregnancies, led to this research being conducted. A qualitative method was used to determine how women felt physically and emotionally following vaginal childbirth. In total, nine women were selected using convenience and purposive sampling and were interviewed between 3–6 months postnatally. Interviews were taped and transcribed verbatim.

An eight-point multifaceted approach has been designed to improve postnatal health in areas where a deficit had been uncovered. This research demonstrated areas of concern in postnatal health, in particular, incontinence and perineal pain. It has also highlighted areas of care provision that need improvement.

Keywords: Perineal, Suture techniques, Urinary incontinence, Faecal incontinence, Episiotomy, Pelvic floor, Postnatal care, Pain, Dyspareunia

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Up to 85% of vaginal births result in perineal trauma, of which 69% require suturing (McCandlish et al, 1998; Liu, 2007). It has been suggested that suturing can increase the risk of dyspareunia (Kettle et al, 2002; Layton, 2004), increase the prevalence of incontinence (both urinary and faecal) (Thompson et al, 2002; Layton, 2004) and exacerbate perineal pain (Kettle and Johanson, 2000; Hedayati et al, 2003). In the *Hospital Episodes Maternity Statistics 2012-13* report (Health and Social Care Information Centre, 2014), 503 972 vaginal births were recorded between 2012 and 2013, of which 74% of women experienced significant perineal trauma. However, there still appears to be no long-term monitoring of women's experiences of childbirth trauma and what effect it has on their lives. Furthermore, no professional body appears to take ownership in the care of these women once they have been discharged from midwifery care (Williams et al, 2007).

Midwives' public health role is expanding (Nursing and Midwifery Council (NMC), 2012); therefore, it is pertinent to ask whether midwives should be involved in the longer-term management of these issues and refer any women experiencing such problems to their GPs or directly to appropriate specialists rather than discharging women whose wounds appear to have physiologically healed. The Royal College of Midwives (RCM) (2001), Department of Health (DH) (2007) and the *Midwifery 2020 Programme* (DH, 2010) also advocate the development of the role of the midwife in medium- and long-term outcomes of maternal and child health.

Over the last 30 years, there have been many changes in what is deemed as best practice in perineal care. On reviewing the literature, there appear to be several areas that may contribute to long-term perineal health. These include: hands on or hands poised at birth (McCandlish et al, 1998); assessing for, or performing episiotomy (Sleep et al, 1984; Carroli and Mignini, 2009); whether to suture tears (National Institute for Health and Care Excellence, 2007; Kettle, 2012), if so, with which suture material and technique to use (Kettle et al, 2002); perineal recovery and pain experienced (East et al, 2012), the presence of incontinence and/or dyspareunia (Andrews et al, 2008) and whether pelvic floor exercises (PFE) were performed (Layton, 2004).

There are many studies that state the differing morbidity issues associated with birth, however, they all report on different time periods after childbirth and thus it is difficult to form direct comparisons with each study (Bick, 2009). Many research articles still quote the vaginal birth rate in the UK as 350 000 (Kettle et al, 2002) instead of the 2012–13 rate of 370 984 (Health and Social Care Information Centre, 2014). This underestimation of affected women, combined with conflicting variables of studies, and changes in societal demographics may be contributory factors as to why the wealth of research has not been used to support the need for a structured care pathway for women's long-term health and wellbeing after birth.

The aim of this study is to determine whether women are suffering ill health in the 3–6 month postnatal period, in particular, incontinence or

perineal pain, and offer suggestions to improve current service provision.

Method

In order to examine longer-term health effects of vaginal childbirth trauma, a qualitative method of analysis was used to explore personal experiences described by the participants (Bowling, 2008). Qualitative methods are favoured for their emergent designs and flexibility of data collection in natural settings (Hammersley and Traianou, 2012). This was pertinent in this study, as how the women felt physically and emotionally following vaginal childbirth is the main concern. The important feature was being able to capture what the participants had to say in their own words (Abbott and Sapsford, 1998) while simultaneously observing their mannerisms and descriptions (Litosseliti, 2003). This can also have a bearing on the meaning of what is said and is distorted if a design is used whereby the participant responds without the researcher being present, for example, returning questionnaires. Seidman (1998) believes that adding the behaviour element affords the researcher more information about the meaning of the conversation. This is in contrast to quantitative designs which focus on an objective, systematic enquiry that does not feature personal feelings of either the researcher or subject (Polit and Hungler, 1995). A qualitative approach is debatably considered as more ethically sound when studying people, as opposed to reducing them to numerical values that can be counted or analysed (Hammersley and Traianou, 2012). As the purpose is to gain access to the participants' lives through observation, care should be taken to make clear distinctions between surveillance (Barnes, 1979) and even voyeurism (Denzin, 1992). Finch (1984) believes that open-ended questions may force interviewees to divulge more personal information than would have originally been desired. This can be heightened by feeling lulled into a false sense of security by an overfamiliar researcher. This was taken into consideration in the design of this study by reducing the amount of open-ended questions and being mindful of the rapport between researcher and participant. Process consent was sought at regular intervals to ensure participants remained comfortable with the study (Polit and Beck, 2006). Semi-structured interviews were used to determine the women's own personal perceptions and a guarantee of anonymity was given, prior to informed consent being obtained. The interviews were recorded and typed verbatim by the researcher.

Population and sample

The study involved participants who had given birth vaginally between 3–6 months ago. Some of the women had assisted deliveries; however, the majority had normal vaginal births, including a water birth and a home birth.

The study was conducted at two centres that hold postnatal groups. They are run by community midwives employed by the same NHS Trust, where the researcher works as a midwife. Thus it was both a convenience and purposive sample (Parahoo, 2006). It is difficult for midwife researchers to access postnatal women after they have been discharged from midwifery care, as postnatal groups are uncommon in many NHS Trusts (Kennedy, 2009). The women attending the groups had given birth at three local hospitals. The two groups are situated in two opposing socioeconomic areas, which was a carefully considered factor when designing the study, as although a small number of women participated, a cross-section of the community was included. Group A is situated in an affluent area and group B is at the heart of a social housing estate where many of the residents are impoverished (Birmingham City Council, 2011).

A sample of 10 women (approximately five at each group) was the initial target, as recommended by Holloway and Wheeler (2010).

Nine women were interviewed, as this provided ample data for the study. This was determined by confirmation that no new data were revealed after participant number seven, however, to be sure of this two more were interviewed after to verify saturation.

Ethical reviews

Prior to commencing this research, three levels of ethical approval were sought. The proposal was approved initially by the University of Wolverhampton Ethics Committee, then by the National Research Ethics Service (NRES) and finally the Research and Development Department at the Foundation Trust.

Data analysis

The method of narrative analysis used was thematic analysis. Researchers use this method to categorise themes that emerge in the data and identify subgroups to determine the frequency or patterns that occur within the texts (Liamputtang, 2009). The narrative produced six main themes which were further broken down in to 19 smaller sub-groups (*Table 1*).

It was difficult for the researcher to remain impartial when interviewing women and not interact with the participant. The notion of reflexivity or acknowledging the inevitable interaction between the interviewer and interviewee is paramount. This was particularly evident in cases where the woman

Table 1. Themes identified from from the data

Themes	Sub-groups
1. Pain	a) Postnatal b) Analgesia c) Pain scale
2. Sexual intercourse	a) Dyspareunia b) Abstinence
3. Incontinence	a) Embarrassment b) Urgency c) Incomplete voiding d) Lifestyle change e) Normalising f) Stress incontinence
4. Health professionals' responsibilities	a) Inappropriate referral b) Inappropriate explanation/care
5. Support/coping	a) Would have liked more support b) Postnatal depression
6. Pelvic floor exercises (PFE)	a) Advised to do PFE after problem b) Unable to do PFE properly c) When/ how to do

was suffering or had experienced less desirable care. Burns et al (2012) conducted a qualitative study on reflexivity in midwifery research. The participant observational study whereby midwife researchers examined breastfeeding support, highlighted the advantages of being a midwife in order to initially 'get in' or 'fit in' in order to conduct the research. This is known as the insider/outsider concept and supports how the researcher felt during the study. Recruitment was difficult in this study, due to the nature of the subject in question. If the researcher had not been a midwife, the feeling was that there would have been less or no involvement by the participants. As the study moved to the data collection phase, it was extremely difficult to be a researcher first and a midwife second. This phenomenon was illustrated by Burns et al (2012: 52) who describe the:

> ***'...unanticipated role ambiguity, and moral and ethical challenges, [that] arose as a result of this 'insider' knowledge and status.'***

A pilot study was not carried out as the research is qualitative in design and thus the focus was to use a small number of participants. It is acknowledged that 'saturation' was reached before the initial figure of 10 participants were interviewed (Holloway and Wheeler, 2010).

Results

Thematic analysis of the data revealed six main themes (*Table 1*). Examples of some of the quotations are provided to illustrate some of the topics determined.

Pain

The results showed that six of the nine women interviewed reported pain in the postnatal period. The earliest that perineal pain was reported to be resolved was at 4 weeks for participant 009 who said she still felt pain after the midwife had discharged her at 14 days.

Pain affected participant 006's life in such a way that she said:

> ***'I've never had that before I don't even know what it is, my down below hurt me so much when I try to move or sit down. I can't explain. Horrendous shooting pains in my vagina.' (Participant 006)***

It was deduced that pain was prevalent postnatally between 3–6 months in six of the participants interviewed.

When participant 003 was asked about perineal pain specifically, she said:

> ***'I used to...I know for definite before I had the painkillers I was still getting pain in that area....probably 20 weeks easily.' (Participant 003)***

Of the six women who reported postnatal pain, four required analgesia. The women were asked to record the pain they experienced using the pain scale, whereby 1 indicated the least amount of pain, and 10 the most.

Participant 001 reported a reduction in pain at 3 months:

> ***[at 3 months] 'now it's probably only 3–4.' (Participant 001)***

Thus inferring that the pain she experienced was originally more than this. The overall average number on the pain scale reported was 3–4, between 3–6 months postnatally. It is acknowledged that this is a snapshot at the time of each interview and does not explain the changing values that may be experienced with time.

Sexual intercourse

Dyspareunia

The women that reported dyspareunia had split from the babies' fathers and felt this was a determining factor in the relationship breakdown.

'At about 8 weeks, just after my check up at the GP surgery I, err, tried to have intercourse with my partner at the time and errrmm it wasn't very enjoyable, let's just say...It was painful but errrmmm not totally unbearable it was just bearable but it wasn't enjoyable errrmmm I'm not with him now and that was quite a significant thing at the time.' (Participant 008)

The pain experienced during intercourse in the postnatal period, or the fear of the pain, can influence relationships as well as how the woman feels.

Abstinence

Fear of intercourse caused participant 001 to abstain from sex, she said:

'I won't even go near him at the moment because I'm too scared having had the stitches.' (Participant 001)

For participant 003, she acknowledged refraining from coitus and said:

'It took us a long time to get intimate again.' (Participant 003)

Incontinence

Embarrassed

Four of the interviewees were embarrassed by either the reality or possibility of incontinent episodes. Participant 001 was:

'...paranoid of what I was wearing in case it happens.' (Participant 001)

Participant 004 had not experienced incontinence, but felt it may happen:

'I wear it [pad] as a back-up because I wouldn't want the embarrassment if it did happen.' (Participant 001)

Participant 008 was conscious of just making it to the toilet, and of the odour. She said:

'I only just make it sometimes, bit embarrassing...often my pants smell a bit of urine as well which isn't very pleasant. That makes me feel really self-conscious.' (Participant 008)

Urgency

Participant 006 explained how the urgency is not consistent. She said:

'I used to have good bladder control but now I need the toilet more. It's like sometimes I can hold it and sometimes I can't and I didn't notice that before...I had literally been rushing to the toilet.' (Participant 008)

Interestingly, she had been unable to void for several days prior to and during labour.

Participant 005 originally felt she had no postnatal problems, then she said:

'I know if I need a wee, I don't think I got as long... I can't hold it as long as I used to be able to.' (Participant 005)

Incomplete voiding

For participant 007, the failure to empty properly is due to lack of visiting the toilet. She said:

'errrrmm I don't wee very often I wee once a day since the baby's birth...when I do go it does feel a bit sore like I have been holding it in for a while but I don't.' (Participant 007)

With participant 006, the inability to empty the bladder occurs during passing urine. She said:

'I think I have a wee then I dribble a little bit.' (Participant 006)

This was similar with participant 008, who said:

'I can't feel it but I have noticed sometimes there is a dribble—quite a dribble of urine it's almost as if I haven't emptied myself properly but I thought I had.' (Participant 008)

Lifestyle change

Participant 001 explains:

'and so I worry about not drinking anything while you're out so your bladder's not too full in case you need to use the toilet. I don't drink in the daytime.' (Participant 001)

She had to schedule shopping trips to enable access to the toilet facilities.

Participant 008 was asked if she would like more children, she replied:

'Obviously with this urine thing I feel like I am already damaged, what would

another baby do?' (Participant 008)

Stress incontinence

Many of the women admitted having stress incontinence:

> ***'Certain things I can't do because I've got absolutely no control really. When I do a circuit class if I do skipping or star jumps or anything like that I completely lose control of my bladder.' (Participant 002)***

> ***'If I errmm sometimes cough and sneeze I leak though.' (Participant 009)***

Normalising

This parameter was particularly alarming, as almost half of the participants did not feel they had a problem when clearly there was an issue. When asked about toilet habits after childbirth, participant 002 said:

> ***'No they're fine…I mean I consider myself to be quite lucky and haven't had any postnatal complications at all really.' (Participant 002)***

However, participant 002 cannot join in with skipping and soaks a pad during the gym class. She rationalised this:

> ***'I suppose it's because I don't run everywhere and it's not happening every 5 minutes in the day I'm not considering that it is impacting on my life.' (Participant 002)***

Participant 005 felt she was 'fine' yet later reported a self-diagnosed prolapse.

Health professional responsibilities

Inappropriate referral

In response to being asked if a consultant appointment was arranged for the 6 week examination, participant 001 said:

> ***'they did try and get me seen while I was in hospital errr but they couldn't get through to anyone…No one contacted them back.' (Participant 001)***

It transpired that despite the fact that she had shown signs of incontinence in the hospital and had been promised a referral to a consultant for this, she ended up with a routine 6 week postnatal appointment with a practice nurse.

Participant 009 said:

> ***'If I properly laugh or sneeze I sometimes leak and I have gone to the doctors with that.' (Participant 009)***

She was then asked what they did and replied:

> ***'nothing really. They mentioned pelvic floors back then but that was when my child was 5 months old. I tried that and went back and they kept saying try your pelvic floor muscles and that's all they did.' (Participant 009)***

and no subsequent referrals were made regarding her stress incontinence.

Inappropriate explanation or care

When asked if she was told about the extent of her tear, participant 001 said:

> ***'no I think they told my husband. I was so high on the gas and air, it's all coming back now…all I know is the back wall ripped. I don't know how many stitches though?' (Participant 001)***

Thus demonstrating not only a lack of knowledge of her own wound but this also highlights an inappropriate discussion of this personal information with her husband without her prior consent.

Support/coping

Regarding support in the postnatal period, participant 006 admitted:

> ***'Really looking back I needed more support.' (Participant 006)***

When asked for clarification as to whether the birth, or any issues afterwards, had put her off having another baby, participant 009 said:

> ***'both, the after as well…not having any support or guidance or anything like that puts me off. It would be nice to have that support and I didn't have it with either children. My friends that have had children—I speak to them about it but they didn't have the traumas that I had. They just had normal deliveries, no stitches, normal.' (Participant 009)***

Despite the fact that all of the women talked to

their family and friends about childbearing issues, it is evident that the majority still require more support in the postnatal period.

Pelvic floor exercises

The midwife on the postnatal ward told participant 001 about pelvic floor exercises after she was incontinent in the hospital:

> ***'not until I had started to not be able to control my bladder.' (Participant 001)***

From the study it is evident that pelvic floor exercises were not being routinely discussed in the detail required.

Only when a problem was apparent was participant 003 advised to do pelvic floor exercises, she said:

> ***'I was getting pain...she [midwife] said that I wasn't written up for any [tramadol]...which I found out I was so she didn't give me any tramadol on the night. She told me just to do some pelvic floor exercises to try and like and that would help with the healing sort of thing so I gave that a go and I was uncomfortable...' (Participant 003)***

When asked to explain how the midwife advised her to do her pelvic floor exercises, participant 003 said:

> ***'Well she just said do the squeezing sort of thing of the pelvic floor ermm like you're stopping yourself from having a wee sort of thing and so that's what I had done. She said do it as much as I can and when you can't do it any more your body will tell you when to stop sort of thing.' (Participant 003)***

Discussion

Although the actual incidence of dyspareunia following childbirth is vastly under-diagnosed (Layton, 2004), some of the participants offered to talk about dyspareunia without being prompted as it developed as a natural progression of the conversation. Despite it being a sensitive issue, up to 23% of women may still experience superficial dyspareunia at 3 months postnatally (Sleep et al, 1984). O'Malley and Smith (2013) believe that some aspects of sexual health may not be recovered by 6 months postpartum including: timing of resumption of sexual intercourse, dyspareunia, sexual desire/arousal/satisfaction, orgasm and vaginal dryness. Therefore, it is important that a woman has access to a health professional whom she feels she can confide in. The researcher felt privileged that some of the women had shared that information with her and served to amplify the importance of a health professional conducting this research; it may also imply that health professionals have the necessary skills and knowledge to oversee the women for longer periods after childbirth. As the researcher is herself a midwife, this may have aided in putting the women at ease on a topic they are used to discussing with midwives, however, it is also acknowledged that it may create bias. This was reduced by interviewing away from the maternity unit and being referred to as the 'researcher'. It was also important to remain objective and not offer any midwifery advice during the interview. This engagement is thought to be unique to trained health professionals and Serrant-Green (2005: 13) describes (nurses) interviewing as a way of

> ***'reducing the distance between the researcher and participant.'***

However, caution is given to ensure the boundaries of 'chatting' and obtaining the information for the research are determined.

Incontinence is thought to be under-diagnosed, between 19% (Sleep et al, 1984) and 53.8% (Williams et al, 2007) of women are thought to have urinary problems and up to 10% may be suffering faecal incontinence (Sultan et al, 1993; Williams et al, 2007). Calvert and Flemming (2000: 407) stated that:

> ***'Further postpartum morbidity has been seen to affect many women, but is often unrecognised by practitioners.'***

It should also be noted, however, that women not reporting the symptoms to health professionals may be a contributory factor. The incidence of incontinence being much higher than the referrals is thought to be due to embarrassment and women accepting it is a consequence of childbearing (Mason et al, 2001; Bick et al, 2002), or because the question has not been asked. Awareness of the frequency of the problem and the services offered may encourage self-referral or admission to the relevant health professionals. In particular, non-surgical options such as lifestyle interventions, physical therapies, behavioural therapies, drug therapies, less-invasive procedures for overactive bladder and stress incontinence, urodynamic testing, imaging and pelvic floor assessment could be sought (National Collaborating Centre for Women's and Children's Health (NCCWCH), 2006). Understanding these

options may influence women to report issues if the extent of treatment is not always invasive.

In principle, GPs are the lead professionals in the field of community health, however, this does not seem to be the optimal model of care for encouraging postnatal women to engage with services. Participants 006 and 008 both depicted the health visitor role as being inappropriate to discuss incontinence, and participant 001 did not feel it was the practice nurse's remit as the nurse asked her to tell the doctor on her next visit. The obvious choice, therefore, would be a midwife. From the results of this study, it appears that the 6 week puerperium (Myles et al, 2009) is not enough time for adequate recovery. This was also supported by Wray (2011) who conducted a grounded theory study of 11 British women in the early postpartum period. Currently, women are entitled to free dental care and prescriptions (NHS Choices, 2013) and maternity leave (Department for Business, Innovation and Skills, 2011) up to and including 1 year following childbirth, as it is acknowledged that women need time to heal for their bodies to return to a pre-pregnant state and adjust to their new role and responsibilities. This time frame was also the focus of Williams et al's (2007) research that investigated the morbidity experienced as a result of birth trauma. This concept of 1 year, therefore, appears to be a sensible arbitrary figure to extend the time frame of a midwife's input. This would allow women to realise if a problem was persisting and to provide a named person to discuss this with. The NMC (2012: 6) states that it is a midwife's duty to provide postnatal care

> '***...not less than 10 days and for such longer period as the midwife considers necessary***'.

highlighting that the requirement for postnatal care provision is vague yet could be interpreted to extend to a year. In the *State of Maternity Services* (RCM, 2012) report, it was suggested that midwives need more resources in order to improve public health care provision. It is also stated that the quality of antenatal and postnatal care should be as important as at the birth itself. Service providers therefore need to consider the local provisions and determine whether postnatal provision needs to be developed.

The proposal for improving postnatal ill health would be a multifaceted approach taking into consideration the reported problems and thus the required service provision. Beake et al (2012) suggest three main considerations to improve postnatal care:

- Workshops for midwives and maternity support workers to enhance their knowledge and thus improve how the women are educated
- A more detailed postnatal health record to include timing of contacts
- Revision of the current postnatal information booklet.

The author agrees that while this is an improvement on current measures, an extrapolation of this proposal is further required to address care deficits. From the information sought from this study (and on reviewing others), the postnatal health record should indeed contain more detail, however, the schedule of care should be mapped to encourage contact around the patterns of the particular ill health issues. For example, if it is known that pain persisting at 3 months, that is registering an average of 3–4 on a pain scale, is unacceptable, then a suitable health professional should be questioning this descriptor after the usual 10-day healing period. This is to encourage early detection of abnormal healing and thus provide referral and/or treatment, if necessary. In formulating a postnatal care plan, it is paramount that key points are factored into the design. For example, it is well documented that parity, epidural analgesia, episiotomies, instrumental deliveries and the severity of perineal trauma, all contribute to higher levels of pain (Buchan and Nichols, 1980; Thacker and Banta, 1983; Cater, 1984; MacArthur and MacArthur, 2004). This should be acknowledged and measures put in to place to reduce this phenomenon. This could also incorporate the recommendations from the Centre for Maternal and Child Enquiries (CMACE) in postpartum sepsis reduction (Cantwell et al, 2011). CMACE found that the maternal death rate, specifically relating to sepsis, is still alarmingly high and needs addressing. Explaining to women the signs and symptoms of infections such as group A streptococcus, and how to reduce their risk, (Cantwell et al, 2011), not only empowers them, but would improve understanding of the healing process. This would allow women to take some responsibility for taking action and escalating concerns.

If women are not provided the full information on their postnatal care, they will be unable to decide whether or not there is a problem and may not present to a health professional for diagnosis. For example, the West Midlands Perinatal Institute (2012: version 12.1) birth notes currently have a small section on perineal trauma. This involves ticking boxes as a checklist to demonstrate which topics have been discussed. This does not provide space to document exactly what has been explained in detail, regarding the healing process and thus deciphering when there may be a problem. Midwives should be aware of the phases involved in wound healing, in order to promote optimum conditions for the healing process and to determine any delays or

complications. The majority of sutured perineal wounds heal by first intention (restoration of tissue continuity occurs directly, without granulation) and occasionally second intention (wound repair following tissue loss is accomplished by closure of the wound with granulation tissue) (Scanlon, 2003) and this process should take approximately 7–10 days. In the presence of infection, a delay of 4–5 days in the initial closure due to contamination can take place, thus a midwife should be inspecting to see if there is evidence of wound breakdown by this point in time. This should be a 'mapped visit' in the puerperium. By the 5th or 6th day, a phase called 'contraction' commences, which is responsible for reducing the size of the wound (Steen, 2007). When planning individual care for a woman, special attention should be given to women who are: experiencing any form of stress, medical conditions, infection or obesity, extremes in age groups, smokers, exposed to poor housing and diet and/or prescribed certain drugs (Steen, 2007), as these can hinder the healing process.

When documenting advice given about pelvic floor exercises, the following should be shown to have been discussed:

- How and when to do them
- Why the exercises are important
- What the exercises should expect to feel like
- Frequency
- What to do if the woman is unable to carry out the exercises or it is painful to do so.

Currently, there is a box to tick when pelvic floor exercises have merely been 'mentioned'. The limited space provided for documentation in this area, again lessens the importance and thus 'normalises' the potential issues. An example of the standard of advice required to be given on pelvic floor exercises is seen in the leaflet by the Association of Chartered Physiotherapists in Women's Health (2009) and thus this level of detail needs to be imparted to the women and recorded appropriately.

Recommendations

The authors recommend an eight-point multifaceted approach has been designed to improve postnatal health:

- Expand the role of the midwife to be the lead care provider for women for up to 1 year after childbirth
- Ensure the specialist services are available in order for midwives to refer ill health cases to
- Audit postnatal readmissions and referrals to provide information to the Clinical Commissioning Groups and service providers on trends and numbers
- Encourage women to take responsibility for personal hygiene and reporting areas of postnatal ill health by educating and empowering them with the knowledge required
- Educate health professionals and encourage a more detailed approach to advising women on signs of ill health and becoming more transparent about postnatal problems. This should include inspecting the perineum in the postnatal period until complete visible healing and pain subsidence has occurred
- Standardising pelvic floor exercise advice in line with the recent RCM and the Chartered Society of Physiotherapy (Gerrard and ten Hove, 2013) position statement. This would include risk assessments, what is said, documentation and follow up
- Improving the postnatal health records to include more space for documentation of common issues, alongside sections of standardised advice
- Mapping postnatal contacts by the midwife around key times throughout the year to coincide with when problems are likely to present, thus maximising opportunity for detection.

Limitations

It is acknowledged that there are many variables in this study, however, this was duly considered as the researcher wished to include all women who had had a vaginal birth. As their previous and current childbirth information and demographics were determined at interview, it was possible to see the variances between the respondents within the group, as necessary.

The sample, albeit small, were selected from two different sociodemographic areas within a large city, therefore, the results may not be transferable nationally.

Conclusion

It was difficult to remain impartial as a midwife and most of the participants benefitted from having contact with the researcher during this process. All of the participants expressed some form of unsatisfactory aspect of postnatal health, and sometimes normalised their situation. In the majority of cases, the women were not referred appropriately or at all and suffered in silence.

An eight-point multifaceted approach has been designed to improve postnatal health in areas where a deficit had been uncovered. This has been formulated with commissioners, service providers, service users and health professionals in mind and by using national and local policies to support the recommendations. The researcher still being in clinical practice and thus having 'insider knowledge' was an important factor in the design.

Key points

- Many women are suffering ill health following vaginal childbirth
- Normalising postnatal ill health is apparent. Women expect to be damaged following childbirth and feel lucky if they are not
- The current model for longer term postnatal care provision does not appear to be fit for purpose
- Educating staff and the women would improve self-referral and detection of common postnatal problems
- Expanding the role of the midwife and adopting a structured referral pathway would send a clear message to women that they should not be troubled by these symptoms

This research has been valuable in demonstrating areas of suffering in postnatal health, in particular, incontinence and perineal pain. It has also highlighted areas of care provision that need improvement. Future large-scale studies could be conducted to determine how many women are suffering, which problem is more prevalent and when these occur most frequently in the postnatal period. This would aid in tailoring the services required and timing of contacts by an appointed lead health professional. **BJM**

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