CJNR, 2002, Vol. 34, No. 4, 71–81

Evidence of Adequacy of Postpartum Care for Immigrant Women

Deborah Katz and Anita J. Gagnon

Cette étude pilote a été effectuée dans le but de déterminer s'il y a besoin de mener ou non une recherche à grande échelle sur la pertinence des soins postnatals dispensés aux femmes immigrantes chez qui on a décelé certains problèmes sociaux ou de santé. On s'est appuyé sur un modèle descriptif et transversal pour recueillir des données dans les dossiers de santé et d'hospitalisation de 22 femmes immigrantes qui avaient fait, à cause de problèmes sociaux ou de santé, un séjour à l'hôpital plus long que la moyenne (plus de 36 heures). Les résultats révèlent que de 40 % à 100 % des problèmes n'avaient pas été résolus selon ce qu'indiquent les dossiers et que 30 % à 100 % des familles n'avaient pas reçu les soins optimaux présentés dans les manuels. Même en tenant compte des erreurs de mesure attribuables à la consignation des observations dans les dossiers, la rareté des données attestant de la pertinence des soins relatifs à certaines préoccupations précises et des soins postnatals suggèrent que les soins que reçoivent les femmes immigrantes pendant cette période sont peut-être sous-optimaux. Il ressort donc de notre étude qu'il est impératif d'entreprendre une recherche plus vaste pour approfondir ces questions.

Mots-clés : soins prénatals, femmes immigrantes

The purpose of this pilot study was to ascertain the need for a large-scale investigation of the adequacy of postpartum care for immigrant women in whom health and/or social concerns have been identified. A descriptive, cross-sectional design was used to gather data from hospital and community health records of 22 immigrant women who had been found to have health or social concerns requiring a longer than usual postpartum hospital stay (more than 36 hours). The results show that 40% to 100% of concerns were not recorded as having been resolved and 30% to 100% of families were not recorded as having received optimal care as defined in the literature. Even allowing for measurement error due to recording failures, the paucity of recorded data to support adequacy of care for specific concerns and adequacy of postpartum care suggests that immigrant women may be receiving sub-optimal care in the postpartum period. Therefore a larger, more definitive investigation of these issues is imperative.

Keywords: postpartum, nursing care, health services, immigrant, women

---

Deborah Katz, RN, MSc, is Educator and Consultant, Vancouver Coastal Health Authority, Vancouver, British Columbia, Canada. Anita J. Gagnon, RN, MPH, PhD, is Assistant Professor, McGill School of Nursing, Department of Obstetrics and Gynecology, McGill University, and Nurse Scientist, McGill University Health Centre – Royal Victoria Hospital Site, Montreal, Quebec, Canada.

Introduction

Postpartum hospital stays have decreased significantly in the last two decades (Wu Wen, Liu, & Fowler, 1996), resulting in harmful health outcomes when appropriate follow-up has not been assured (Edmonson, Stoddard, & Owens, 1997; Kotagal, Atherton, Eshett, Schoettker, & Perlstein, 1999; Lee, Ballantyne, Elliott, & Perlman, 1994; Lee, Perlman, Ballantyne, Elliott, & To, 1995; Liu, Clemens, Shay, Davis, & Novack, 1997; Lock & Ray, 1999). Inadequate follow-up may be especially detrimental to immigrant women due to cultural, linguistic, and socio-economic factors impacting upon the postpartum experience. Despite this vulnerability, the provision of postpartum care to this population has been markedly under-studied (Kinnon, 1999).

Postpartum Needs of Immigrant Women in an Environment of Short Hospital Stays

The consequences of inadequate post-discharge care following childbirth have been documented extensively (Edmonson et al., 1997; Kotagal et al., 1999; Lee et al., 1994; Lee et al., 1995; Liu et al., 1997; Lock & Ray, 1999) and are most significant for breastfed infants, who may be at greater risk of dehydration in the early postpartum period (Cooper, Atherton, Kahana, & Kotagal, 1995). In order to address these and other health issues, postpartum care should include contact with the mother and infant within 24 hours of hospital discharge and a home visit by a qualified health-care professional within 48 hours of discharge when discharge occurs less than 48 hours postpartum (Society of Obstetrics and Gynaecologists of Canada, 1996), assessment and prevention of early infant dehydration (Health Canada, 2000) and infant jaundice (Melton & Akinbi, 1999), and early provision of breastfeeding support (Sikorski & Renfrew, 2000). Furthermore, postpartum care should include education in family planning (Hiller & Griffith, 2000) and immunization (Nicoll, Elliman, & Begg, 1989) and, in the case of high-risk families, support by a lay worker through home visiting over a lengthy period (Eckenrode et al., 2000; Kitzman et al., 1997; Olds et al., 1998; Olds et al., 1999).

Although there is evidence that these interventions result in improved health, they are not yet being uniformly implemented in North America. As a result, many women are discharged from hospital to an environment of inadequate postpartum care (Soskolne, Schumacher, Fyock, Young, & Schork, 1996; Young, 1996). Although this lack of follow-up care has been shown to have detrimental health outcomes for the general population, there have been suggestions that

immigrants receive more postpartum services because they are perceived to be at greater risk. Little research has been conducted to confirm this assertion or, more generally, to examine the impact of short stays on immigrant women.

Studies of the psychosocial needs of immigrant new mothers in the postpartum period have found that these women frequently feel overwhelmed and socially isolated. Functioning in an alien health-care system and separation from traditional postpartum practices and support networks adds to the postpartum challenges of immigrant women who must simultaneously deal with the physical, psychological, and emotional demands of new motherhood (Barclay & Kent, 1998; Glasser et al., 1998; Nahas, Hillege, & Amasheh, 1999). We were interested in the extent to which optimal postpartum care is being provided to immigrant women with health and/or social complications.

Purpose

The purpose of this pilot study was to determine whether there is any evidence of the need for a large-scale study of postpartum care delivered to immigrant women in whom health and/or social concerns have been identified. We sought to: (1) determine whether documented health and social problems resulting in extended hospital stay of immigrant women and their infants were addressed in the additional time in hospital and thereafter in the community, (2) describe recorded evidence of continuity of care between the hospital and a community health centre, and (3) describe recorded postpartum care delivered in the community.

Design

A descriptive, cross-sectional design was used to gather data from hospital and community health centre records of immigrant women who had been found to have health or social problems requiring a longer than usual postpartum hospital stay (i.e., more than 36 hours). Although family interviews would have provided more extensive data than a record review, we were interested primarily in the existence of *any* evidence to continue this line of inquiry and believed a record review was the most efficient way to gather such evidence.

Sample

All consenting breastfeeding women born outside Canada, living in the catchment area of the community health centre proximal to the hospi-

tal, giving birth between January 1997 and September 1998 inclusive, and requiring a longer than usual postpartum stay were included in the study. Prior to recruitment, approval was obtained from the Research Ethics Committee of the hospital.

Of the 1,393 mother-infant pairs initially to be discharged within 36 hours postpartum, 113 were found to have a health or social issue requiring a hospital stay longer than 36 hours. Of these, 53 had been born outside Canada. Twenty-two of the 53 lived in the catchment area proximal to the hospital. Community health centre records were located for 20 of the 22 families. Thus, although small in number, the 22 families represented all those who met the criteria over the 21-month period, and 90.9% of these families were included in the sample.

Approximately one third (seven out of 20) of these women had been living in Canada for less than 3 years (*range* = 0–3 years). The majority were multiparous (12) and had less than university-level education (15). The average age of the women in the sample was 29.6 (*range* = 22–38 years). There were nine countries/areas of origin represented in the sample: Morocco (4), Central America (3), China (3), Philippines (3), Africa (2), Eastern Europe (2), Grenada (1), Pakistan (1), and United States (1).

Methods

Records of hospital and community care provided to all women in the sample during the first 2 months postpartum were reviewed. Data were coded and organized into three broad categories based on the health or social problems requiring the longer postpartum hospital stay: breastfeeding difficulties, psychosocial issues, or maternal and infant physiological issues.

Data were further coded according to evidence of interventions addressing the problem and evidence of its resolution. Categorization and coding schemes were pre-tested. Data were collected independently by two individuals; disagreements in coding were discussed until consensus was reached. Data were analyzed descriptively.

Findings

Table 1 shows the recorded follow-up care to address the reasons for the longer hospital stay.

In all 20 mother-infant pairs, hospital nurses recorded having addressed the identified concern. For 16 of the 20 pairs (80%), there was

Table 1 ***Issues Identified and Addressed by Hospital and/or Community Nurses***

	Reason for Longer Hospital Stay (n = 20 mother-infant pairs)			
Setting of Care	Breastfeeding difficulty $n=8$	Maternal psychosocial issues $n=5$	Infant physiological issues $n=4$	Maternal physiological issues $n=3$
Identified by hospital nurse:	8	5	4	3
– resolution recorded	2	1	1	0
– referred to community health centre	1	2	0	0
Identified by community nurses:	5	1	1	2
– resolution recorded	1	0	0	1

no evidence that the issue had been resolved prior to discharge. For example, if a woman required a longer stay due to a breastfeeding issue, the nurse may have recorded that she addressed the issue (e.g., through a teaching intervention), but there was no record of improvement or resolution. With regard to community follow-up, for 11 pairs (55%) there was no evidence that the issues for which they had required a longer hospital stay had been addressed in the community.

Eight women were excluded from the sample because of breastfeeding difficulties. Resolution of the difficulty was recorded prior to discharge in two women and one additional woman was referred to the community health centre for follow-up. There was no recorded resolution of breastfeeding difficulties in the remaining five women. Of the six women identified in hospital as experiencing unresolved breastfeeding problems, five were still experiencing these problems when they were contacted by the community nurse after discharge, and one had already switched to formula feeding by the time of contact.

In the five women still experiencing breastfeeding difficulties in the community, the nurse recorded having addressed the breastfeeding problems through phone support and/or a home visit in all cases, but resolution of the breastfeeding problem was recorded in only one case. Thus, out of the eight women excluded from the sample because of breastfeeding difficulties, there was no evidence of resolution of the difficulty in four of the women, and one had already stopped breastfeeding before she was contacted by the community nurse.

Community nurses also identified breastfeeding problems that had not been documented previously in the hospital in two additional women. Neither follow-up care nor resolution of these concerns was documented by the community nurse. Both of these women experienced subsequent breastfeeding failure; one of the women presented to the emergency department with a breast abscess at 1 month postpartum and required extensive follow-up by a community wound-care nurse for the abscess-related sequelae.

Thus, a total of 10 women were identified by hospital and/or community nurses as having breastfeeding difficulties, and resolution of these difficulties was recorded in three women. There was one case of breastfeeding failure before the time of first contact by the community nurse and two cases of breastfeeding failure in the first month postpartum. For the remaining four breastfeeding women, resolution was not recorded.

Responses to identified maternal psychosocial issues were similar to responses to breastfeeding difficulties, with evidence of a lack of referral and community follow-up care. Of the five women excluded from the sample due to psychosocial issues, in one case resolution was recorded and two of the remaining four cases were referred by the hospital to the community health centre for follow-up care. Once in the community, the psychosocial issues were addressed in only one of the two women referred. Resolution of this issue was not recorded and the duration of contact was limited to the first week postpartum.

For the remaining three women excluded for psychosocial reasons, there was no evidence that their issues were either addressed or resolved. Furthermore, community nurses identified social isolation in four additional women for whom this issue had not been identified previously in hospital. Thus, in total, psychosocial concerns (most notably anxiety and social isolation) were identified by either hospital or community health nurses in nine women, but were reported to have been resolved in only one case.

Outcome data were available for one woman who had been identified by a community nurse as having psychosocial problems in the early postpartum period: this woman had received no follow-up, and presented several months later to the community health centre with severe postpartum depression. Outcome data regarding the remaining seven women were not recorded.

Of the four cases in which the mother-infant pair was excluded because of infant physiological factors, there was evidence of resolution

in only one case prior to discharge. No cases were referred to the community health centre for follow-up. The community nurse serendipitously identified one of the four cases during her contact with the infant in the community, although resolution of the problem was not recorded.

In the three cases where women were excluded for maternal physiological factors, there was no evidence of resolution prior to discharge and there were no referrals to the community. However, in two of these cases the reason for exclusion was addressed by the community nurse during postpartum visitation. In only one of these cases (a case of postpartum hypertension) was resolution recorded.

Table 2 *Frequency of Recorded Community Health-Care Interventions With Various Levels of Empirical Support*

Community Health-Care Interventions	Frequency recorded (per mother-infant pair; $n = 20$)
Strong Empirical Support	
Contact with mother within 72 hours of discharge	8
Frequent home visitation over a long period for disadvantaged mothers	0 (average duration of contact = 9 days; median = 6.5 days; mode = 1 day)
Breastfeeding support	14 (average of 1.45 instances of support)
Assessment and action specific to prevention of dehydration within 72 hours of discharge	6
Moderate Empirical Support	
Assessment and action specific to increasing immunization rates	10
Assessment and action specific to maternal depression	0
Assessment and action specific to family planning	8
Use of lay persons to promote health	1
Parenting education programs	0

In five cases, community health nurses identified physiologic concerns (two infant and three maternal) that had not previously been recorded in hospital. Only one of each of these concerns was recorded as having been resolved. In total, there were 12 cases in which physiologic concerns were identified by the hospital and/or community nurses, with resolution recorded in only two cases.

Table 2 shows the extent to which recorded care was based on evidence of optimal postpartum care. For 12 mother-infant pairs, there was no evidence of contact within 72 hours nor of interventions to address maternal depression and social isolation. For more than half of the sample, there was no evidence of the women receiving education related to family planning or immunization.

Discussion

The results suggest that there is a need for a large-scale study of the adequacy of health-care services delivered to immigrant women and their newborn infants. The record review conducted here, based on all but two families meeting the inclusion criteria, shows a paucity of recorded data to support adequacy of care for specific concerns and for optimal postpartum care as defined in the literature. From 40% to 100% of problems were not recorded as having been resolved, and from 30% to 100% of families were not recorded as having received optimal care as defined in the literature. Even allowing for measurement error due to recording failures, the very small proportions of documented optimal care and resolution of concerns suggest that sub-optimal care is being provided, which warrants a more definitive investigation.

Such an investigation should: (1) supplement or replace record review as the primary data source with interviewer-assisted or self-report questionnaires, or physical and psychosocial assessments, to determine both maternal concerns and actual care received; provincial and other databases may not be able to capture care received by those women who fall into an immigration class and who thus are precluded from accessing services covered by provincial health plans; (2) be comparative in nature, including immigrant sub-populations in various classes and comparing them to Canadian-born women; (3) ensure representativeness through recruitment of a relatively large sample in which health care is provided by a variety of hospitals and community health centres; (4) analyze potential differences by immigration status, length of time in Canada, language ability, education, socio-economic status, and region of birth.

If the figures reported here were to be supported in a larger study, they would suggest that the problems experienced by immigrant women and their infants in the postpartum period are being inadequately addressed in hospital, infrequently used as a reason for referral to community resources, and inadequately addressed in the community even when the problem is identified or a referral is made. Furthermore, they would suggest that some immigrant women are the recipients of sub-optimal postpartum care, exacerbating the risk of harmful postpartum sequelae in this population. With short hospital stays now commonplace, it is crucial that a rigorously designed assessment of care received by immigrant women postpartum be carried out.

References

Barclay, L., & Kent, D. (1998). Recent immigration and the misery of motherhood: A discussion of pertinent issues. *Midwifery, 14,* 4–9.

Cooper, W. O., Atherton, H. D., Kahana, M., & Kotagal, U. R. (1995). Increased incidence of severe breastfeeding malnutrition and hypernatremia in a metropolitan area. *Pediatrics, 96,* 957–960.

Eckenrode, J., Ganzel, B., Henderson, C. R. Jr., Smith, E., Olds, D. L., Powers, J., Cole, R., Kitzman, H., & Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation: The limiting effects of domestic violence. *Journal of the American Medical Association, 284,* 1385–1391.

Edmonson, M. B., Stoddard, J. J., & Owens, L. M. (1997). Hospital readmission with feeding-related problems after early postpartum discharge of normal newborns. *Journal of the American Medical Association, 278,* 299–303.

Glasser, S., Barell, V., Shoham, A., Ziv, A., Boyko, V., Lusky, A., & Hart, S. (1998). Prospective study of postpartum depression in an Israeli cohort: Prevalence, incidence and demographic risk factors. *Journal of Psychosomatic Obstetrics and Gynecology, 19,* 155–164.

Health Canada. (2000). *Family-centred maternity and newborn care: National guidelines.* Ottawa: Author.

Hiller, J. E., & Griffith, E. (2000). Education for contraceptive use by women after childbirth. Retrieved from Cochrane Database of Systematic Reviews (file CD001863).

Kinnon, D. (1999). *Canadian research on immigration and health.* Ottawa: Minister of Public Works and Government Services Canada.

Kitzman, H., Olds, D. L., Henderson, C. R. Jr., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K. M., Sidora, K., Luckey, D. W., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association, 278,* 644–652.

Kotagal, U. R., Atherton, H. D., Eshett, R., Schoettker, P. J., & Perlstein, P. H. (1999). Safety of early discharge for Medicaid newborns. *Journal of the American Medical Association, 282,* 1150–1156.

Lee, K. S., Ballantyne, M., Elliott, I., & Perlman, M. (1994). Early newborn discharge is associated with increased readmission. *Pediatric Research, 35,* 117.

Lee, K. S., Perlman, M., Ballantyne, M., Elliott, I., & To, T. (1995). Association between duration of neonatal hospital stay and readmission rate. *Journal of Pediatrics, 127,* 758–766.

Liu, L. L., Clemens, C. J., Shay, D. K., Davis, R. L., & Novack, A. H. (1997). The safety of newborn early discharge: The Washington State experience. *Journal of the American Medical Association, 278,* 293–298.

Lock, M., & Ray, J. G. (1999). Higher neonatal morbiditiy after routine early hospital discharge: Are we sending newborns home too early? *Canadian Medical Assocation Journal, 161,* 249–253.

Melton, K., & Akinbi, H. T. (1999). Neonatal jaundice: Strategies to reduce bilirubin-induced complications. *Postgraduate Medicine, 106,* 167–168.

Nahas, V. L., Hillege, S., & Amasheh, N. (1999). International exchange. Postpartum depression: The lived experiences of Middle Eastern migrant women in Australia. *Journal of Nurse-Midwifery, 44,* 65–74.

Nicoll, A., Elliman, D., & Begg, N. T. (1989). Immunisation: Causes of failure and strategies and tactics for success. *British Medical Journal, 299,* 808–812.

Olds, D., Henderson, C. R. Jr., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., Pettitt, L., Sidora, K., Morris, P., & Powers, J. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. *Journal of the American Medical Association, 280,* 1238–1244.

Olds, D., Henderson, C. R. Jr., Kitzman, H., Eckenrode, J., Cole, R. E., & Tatelbaum, R. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *Future Child, 9,* 44–65.

Sikorski, J., & Renfrew, M. J. (2000). Support for breastfeeding mothers. Retrieved from Cochrane Database of Systematic Reviews (file CD001141).

Society of Obstetrics and Gynaecologists of Canada (SOGC). (1996). *Early discharge and length of stay for term birth: Policy statement no. 56.* Ottawa: Author.

Soskolne, E. I., Schumacher, R., Fyock, C., Young, M. L., & Schork, A. (1996). The effect of early discharge and other factors on readmission rates of newborns. *Archives of Pediatric and Adolescent Medicine, 150,* 373–379.

Wu Wen, S., Liu, S., & Fowler, D. (1996). Trends and variations in neonatal length of in-hospital stay in Canada. *Canadian Journal of Public Health, 89,* 115.

Young, M. (1996). Acculturation, identité et bien-être : l'ajustement des refugiées Somaliennes [Acculturation, identity and well-being: The adjustment of Somalian refugees]. *Santé Mentale au Quebec, 21,* 271–290.

Authors' Note

This project was supported in part by Fonds de la recherche en santé du Québec.

We would like to thank Kathy Waghorn, Research Coordinator of the Centre for Nursing Research of the SMBD Jewish General Hospital at the time of this study, and the staff of the postpartum unit of the SMBD Jewish General Hospital and CLSC Côte-des-Neiges for their assistance with this project.

Correspondence may be directed to Anita J. Gagnon, Assistant Professor, School of Nursing, McGill University, 3506 University Street, Montreal, Quebec H3A 2A7 Canada. Telephone: 514-398-8994. Fax: 514-398-8455. E-mail: anita.gagnon@staff.mcgill.ca