EARLY HOSPITAL DISCHARGE FOLLOWING CHILDBIRTH: MOTHERS' EXPERIENCES DURING THE FIRST WEEK OF THE POSTPARTUM PERIOD AT HOME IN MZUZU CITY, MALAWI.

MSC (MIDWIFERY) THESIS

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MSc. (Midwifery) Thesis.

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Submitted to the Department of Maternal and Child Health, Faculty of Nursing and Midwifery, in partial fulfillment of the requirements for the degree of Master of Science in Midwifery.

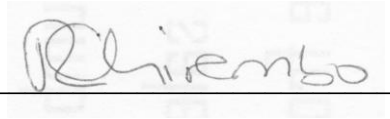
University of Malawi
Kamuzu College of Nursing

MARCH, 2011

DECLARATION

I hereby declare that “Early Hospital Discharge Following Childbirth: Mothers’ Experiences During the First Week of the Postpartum Period at Home in Mzuzu City, Malawi” is my original work except where references are made and has not been presented or submitted in candidature for any other degree at University of Malawi or any other university.

Judith Kalale Chirembo



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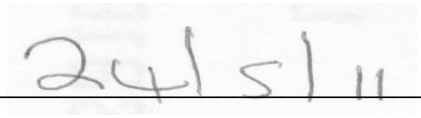

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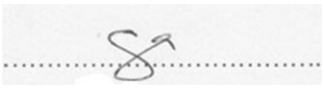
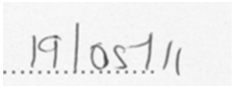
Signature :  Date : 

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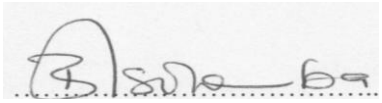
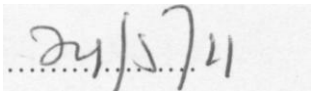
Signature :  Date: 

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DEDICATION

To my father, the late Mr. Biliam Kalale Phiri and my mother, Betrina Namayenda Tsalani, for their untiring encouragement that has made me what I am today. May father's soul rest in peace and may God bless Betrina with a long and healthy life.

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Above all, I am grateful to God Almighty for keeping me healthy and strong throughout the period of my study.

ABSTRACT

There has been a dramatic decrease in the length of time mothers remain in hospital following childbirth, which may affect the health outcome of the mother and neonate in the immediate postpartum period. This is because mothers may have health needs and concerns during the immediate postpartum period related to physical recovery from childbirth, neonatal care, and family relations that may need the midwife's attention. Hence, a descriptive phenomenological qualitative study was conducted to explore mothers' experiences during the first week of the postpartum period following early hospital discharge after childbirth in Mzuzu City, Malawi. In-depth interviews were conducted with 26 participants. All participants had given birth within six weeks prior to interviews and were discharged from the hospital within 24 hours after delivery. Data was tape-recorded and field notes were taken to complement the recorded data. Narratives were analysed following Collaizz's technique.

The results indicated that the majority of participants and their neonates experienced health problems during the first week of the postpartum period. Maternal problems included abdominal pains, excessive bleeding, breast problems and general medical health problems. Neonates experienced neonatal infections such as eye, skin, gastro-intestinal, and general health problems. Very few participants in this study sought medical care for the health problems they or their neonates experienced. However, almost all the participants attended the one-week scheduled postpartum check-up visit. Furthermore, the study revealed that the majority of participants received support from family members, specifically from their mothers, mothers-in-law, husbands, and neighbours during the first week of the postpartum period. The study further revealed that mothers were either satisfied or dissatisfied with early

hospital discharge depending upon the extent of family support they received, the hospital environment, the amount of information they received and health assessment that was conducted in preparation for early hospital discharge, and their personal health status. The results further indicated suggestions for improving the practice of early hospital discharge. Suggestions included follow-up through home visits, telephone calls, scheduled postpartum check-up visits at the hospital and self-report to the hospital if any problem arises.

The study adds insights into health problems that mothers experience during the first week of the postpartum period following early hospital discharge. Therefore, preparation for early hospital discharge should include a thorough health assessment of both mother and neonate to ensure that they are healthy before discharge. Midwives should also educate mothers on normal physiological changes during the postpartum period and that certain signs and symptoms indicate serious health problems. This information will help them to differentiate normal experiences from abnormal ones**.** There is a need for further research to explore the prevalence and types of maternal and neonatal health problems following early postpartum hospital discharge. Furthermore, exploration of the factors that contribute to postpartum health problems in the home during the early postpartum period is necessary. This knowledge will assist in guiding the care and education of mothers following childbirth.

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LIST OF ABBREVIATIONS AND ACCRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
BCG	Bacillus Calmette Guerin Vaccine
CHAM	Christian Health Association of Malawi
COMREC	College of Medicine Research and Ethical Committee
DHS	Demographic Health Survey
EPH	Essential Health Package
HIV	Human Immuno-deficiency Virus
MDG	Millennium Development Goals
MDHS	Malawi Demographic Health Survey
MICS	Multiple Indicator Cluster Survey
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MZCH	Mzuzu Central Hospital
PPH	Postpartum Haemorrhage
SLA	Service Level Agreement
SWAp	Sector Wide Approach
UNICEF	United Nations Children Fund
USA	United States of America
WHO	World Health Organization

CHAPTER ONE

Introduction and Background

Introduction

Traditionally, mothers remained in the hospital for a minimum of 48 hours after uncomplicated vaginal delivery (Wickham, 2005). During this period the focus of care was on postpartum examination for the identification of infection, postpartum haemorrhage (PPH), jaundice, neonatal sepsis, and other complications in order to determine how mother and neonate are adjusting physically and psychologically following childbirth (Lůanaigh & Carson, 2005). Additionally, midwives provided information regarding use of family planning, breast-feeding, personal hygiene, nutrition, self-breast examination, and identification of signs of complications for both the mother and the neonate. Thus, midwives had adequate time for teaching and assessing the mother's health status, knowledge, and skills regarding self-care during the postpartum period. As a result, mothers were leaving the hospital well informed about how to take care of themselves and the neonate.

Currently, the length of time mothers spend in the hospital following childbirth has dramatically decreased in many countries to a minimum of six hours for uncomplicated vaginal deliveries (Brown, Small, Argus, Krasteve, & Davis, 2002; Ministry of Health (MOH), Access, & World Health Organization (WHO), 2008). The practice of early postpartum hospital discharge originated in the Western World (United states of America (USA) and United Kingdom (UK)) as a response to shortage of hospital beds resulting from the baby boom that followed the Second World War in the mid 20th century (Lůanaigh & Carlson, 2005). In addition, medical insurers began

limiting their postpartum coverage. An attempt to manage childbirth as a non-medical condition also contributed to the initiation of early hospital discharge. Malawi adopted the practice of early hospital discharge in the 1990s due to shortage of hospital beds, but there is no documentation that states when this practice was actually implemented (Personal Communication with Chief Nursing Officers, MOH headquarters, Malawi). Additionally, no specific strategies were outlined to ensure continuity of care consistent with WHO guidelines such as home visiting by health professionals. The current postpartum health care package focuses on comprehensive assessment of mother and neonate and health education and counselling on danger signs and health promotion practices (MOH, Access, & WHO, 2008). It is assumed that, equipped with knowledge of the danger signs and health-promotion practices, the mother will be able to prevent or detect any complication and report to the hospital early.

However, the immediate postpartum period is a major event in the mother's life as the mother and the neonate recover from the physical, social, and psychological changes that result from effects of pregnancy, labour, and delivery (Fraser and Cooper, 2009). Literature reveals that 50% to 70% of mothers develop life-threatening complications such as PPH, sepsis, and pre-eclampsia among others during this period (WHO & World Bank, 1997 cited by Lawn & Kerber, 2007). Similarly, neonates are susceptible to problems related to breathing, umbilical cord, feeding, and fever from various causes. Delay in starting appropriate care, even with few hours, for mothers and neonates facing such complications can be fatal or result in long-term disability. For instance, Fort, Kothari, and Abderrahim (2006) report that in developing countries, over 60% of maternal and neonatal deaths occur within 24 hours after childbirth and over 65% occur within the first week of the postpartum period. This implies that most

of these complications develop at home as mothers are discharged from the hospital within six to forty-eight hours after childbirth. Thus, Lawn and Kerber (2007) pointed out that most maternal and neonatal deaths occur in the home regardless of place of delivery. Therefore, if these complications occur in a health facility, which is well equipped to handle such emergencies, effective postpartum care would result in improved maternal and neonatal health outcomes. Unfortunately, the first days following childbirth are the time when appropriate postpartum care services are not accessible to mothers as they are discharged early from the hospital.

Studies that have been conducted in developed countries reveal that there is no detrimental effect on outcome of the mother and newborn following early hospital discharge (Klingner, Solberg, Schumacher, Carlson, & Huss, 1999; Redshaw, 2007; Salaria, Gupta, & Bishit, 2001). Follow-up home care visits, telephone calls, and effective clinical assessment have been identified as contributing factors for good maternal and neonatal health outcome. However, these studies may not be generalized in resource-poor countries where these interventions are not implemented. Brown, et. al., (2002) point out that possible adverse outcomes of early hospital discharge include: delays in detecting and treating infant and maternal morbidity, greater occurrence of breast-feeding problems, decreased maternal confidence in care of self and the baby, less maternal satisfaction with postnatal hospital care, higher prevalence of maternal depression, and increased infant and maternal re-admission.

Experience while working at Mzuzu Central Hospital (MZCH) in Malawi showed that some mothers report back to the hospital with maternal or neonatal health complications within the first week after early postpartum hospital discharge. The hospital data for 2008/2009 fiscal year reveals that out of 2,849 deliveries, 3.5% of

mothers and 16% of neonates were re-admitted within seven days following early hospital discharge (MZCH Maternity Annual Report, 2009). Major reasons for re-admission included puerperal sepsis, anaemia, postpartum psychosis, malaria, and pneumonia. Neonates were re-admitted because of neonatal sepsis, malaria, and jaundice. Statistics from ambulatory maternal and neonatal health services in health facilities within Mzuzu City (Mzuzu Health Centre, MZCH and St. Johns Hospital) did not reveal any information regarding maternal and neonatal health problems experienced during the postpartum period. However, midwives usually inquire about health problems during one and six-weeks scheduled postpartum check-up visits and such information is not recorded. Nevertheless, midwives in these facilities reported that they encounter mothers with health problems (personal communication with the midwives). Additionally, Mzimba District, in Malawi, where Mzuzu City is located was among the districts that experience higher prevalence rates of postpartum health problems such as PPH, pre-eclampsia /eclampsia, sepsis, and depression (Malawi Demographic Health Survey (MDHS), 2005). These findings confirm that many mothers in Mzuzu experience health problems during the immediate postpartum period.

Given the risk of the immediate postpartum period, it is necessary to understand the mothers' experiences during the first week of the postpartum period following early hospital discharge in Malawi.

Background

Postpartum care refers to caring for the mother and neonate during the period following complete expulsion of the placenta and membranes to six weeks (Fraser & Cooper, 2009). During this period the body's altered anatomy, physiology, and

biochemistry returns to the non-pregnant state. In the past, most traditional cultures recognized that the mother needs close care, comfort, and company during this period (Wickham, 2005). As a result there were strong prohibitions and rituals such as seclusion of mother for 40 days with an aim of helping the mother to physically, socially, and psychologically cope with new roles of parenthood. Western medicine previously followed these traditional practices by keeping mothers in the hospital longer (minimum of 48 hours) following childbirth with the aim of identifying and managing any complication that may endanger the survival of the mother and neonate (Olds, London, Ladewig, & Davidson, 2004; Klingner, et. al., 1999). However, early hospital discharge, which refers to discharge of mother and neonate from hospital within 48 hours after uncomplicated vaginal delivery, has limited the time for midwives to discuss, examine, and observe how mothers and family are adjusting to their new role (Klingner, et. al., 1999).

Concerned about the harm that may occur to the mother and the neonate from early postpartum hospital discharge, WHO has developed a postpartum care package with emphasis on early identification, management, and referral of emergencies for mother and neonate through appropriate detection of danger signs and maternal follow-up at three days, seven days, and six weeks (WHO, 2004). WHO further recommends that early postpartum hospital discharge requires post discharge care by home visiting and follow-up by telephone calls; availability of support groups in the community; accessible health facilities; adequate health education during antenatal and postpartum period on health promotion practices such as: personal hygiene, maternal nutrition, exclusive breastfeeding, family planning, and immunization. However, these guidelines by WHO may not be adopted in totality in resource-poor countries because

of limited resources, illiteracy, unavailability of health services to remote areas, and lack of follow-up services (Lawn & Kerber, 2007). For instance, in Malawi, there are no community midwives who can assess how mothers are coping physically and psychologically in their homes.

Despite the failure to adopt all WHO recommendations on early hospital discharge, the current postpartum health care package in Malawi recommends that, the mother be given health education and counselling on health-promotion practices (MOH, Access, & WHO, 2008). Information regarding use of family planning, initiation and maintenance of lactation, breast feeding, personal hygiene, nutrition, self-breast examination, and recognition of danger signs such as excessive bleeding, foul vaginal discharge, severe abdominal pains, severe headache, jaundice, and convulsions for both mother and neonate is provided to the mother. Additionally, midwives have to teach and assess the mother's knowledge and skills regarding postpartum care such as baby bathing and positioning and attachment of the baby to the breast. However, Olds, et. al., (2004) argues that the first 24 hours after childbirth are the taking-in phase and are not conducive to learning. As a result mothers may not retain all the information being taught and they may fail to recall. Consequently, mothers may practice harmful practices that may endanger their lives and that of the neonate despite being provided with adequate information during the preparation for early hospital discharge.

Furthermore, the postpartum care package in Malawi recommends that a comprehensive health assessment of the mother and the neonate be conducted in preparation for early hospital discharge (MOH, Access, & WHO, 2008). Postpartum examination of the mother includes: examination of the conjunctiva for pallor; breast examination; pelvic examination to check for involution of the uterus; observation of

lochia; vital signs in order to identify infection; PPH; deep vein thrombosis; and breast problems which may interfere with breastfeeding (Fraser and Cooper, 2009). The neonate is examined for skin colour to identify jaundice; any bulging fontanel; eye discharges; abdominal distension; state of the umbilical cord; and vital signs to identify neonatal sepsis, and other complications that may develop during the postpartum period. The guide further recommends that mothers should only be discharged when there is no fever, no offensive or heavy lochia, no headache, and no hypertension or hypotension (MOH, Access, & WHO, 2008). However, postpartum complications are unpredictable and do often not occur within 48 hours of childbirth.

Mothers are also to be advised to report to the nearest hospital if any complication arises and attend the scheduled one and six-weeks postpartum check-up visits (MOH, Access, & WHO, 2008). The purpose of scheduled one and six-weeks postpartum check up visits is to ascertain the return of the reproductive organs to pre-pregnancy state and to assess the well being of both the mother and the neonate. However, the one-week scheduled postpartum check-up visit is the time when the most life-threatening period is over and most maternal and neonatal morbidity have already taken place. Additionally, Fort, et. al., (2006) reported that about 70% of mothers do not receive postpartum care in developing countries. For instance, MDHS (2005) revealed that only 2.8% of mothers attended the scheduled one-week postpartum visit and 20% received care at 6 weeks in Malawi. The survey further indicated that only 3.3% of mothers received postpartum care within seven days after delivery in Mzimba District, in which Mzuzu City is located, in Malawi (MDHS, 2005). The 2008 Malawi Millennium Development Goals (MDG) report also indicates that the maternal mortality rate is at 807 per 100, 000 live births and neonatal mortality is at 33 deaths

per 1,000 live births (Malawi Multiple Indicator Cluster Survey (MICS), 2006). Major causes of deaths were PPH (33%) and sepsis (33%) (MOH, 2005). This implies that effective postpartum care to mother and neonate within the first 24 hours and up to the first week should be given a priority. However, there is scarcity of information on what mothers experience when they are discharged early from hospital following childbirth.

Statement of the Problem

Early hospital discharge following childbirth has been practiced in Malawi since 1990s. Since then, there are no strong strategies that have been put in place to monitor and evaluate mothers and neonates' progress during the period between hospital discharge and scheduled postpartum check-up visits at one-week. Strategies such as home follow-up by telephone call and visits by community midwives, community support groups, and easily accessible health facilities are rarely available. Additionally, MDHS (2005) reported that only 2.8% of mothers attended the scheduled one-week postpartum visit in Malawi. Experience while working at MZCH in Mzimba District, in Malawi showed that some mothers report back to the hospital with maternal or neonatal health complications within the first week after early hospital discharge. The hospital data for 2008/2009 fiscal year reveals that 3.5% of mothers and 16% of neonates were re-admitted within seven days following early hospital discharge. Personal recall by midwives in ambulatory maternal and neonatal health services in health facilities within Mzuzu indicated that they encounter mothers with health problems (personal communication with the midwives). In addition, no studies have been conducted to explore mothers' experiences following early hospital discharge after childbirth in Malawi. However, there is need for devising strategies to improve

postpartum care services. Therefore, this research study was carried out to explore the mothers' experiences during the first week of the postpartum period following early hospital discharge after childbirth in Malawi, specifically in Mzuzu City.

Significance of the Study

The findings from this study provide insight into mothers' experiences at home following early hospital discharge after childbirth. Knowledge of the mothers' experience can be utilized by health care professionals in planning and implementing health education programmes to meet mothers' needs following early hospital discharge. This may assist mothers and their families to plan for safe transition from hospital to home after early hospital discharge. The knowledge will also guide the process of reviewing reproductive health policy guidelines and develop strategies for continued midwifery care after early hospital discharge. The study has also identified gaps in the postpartum care for further study.

Broad Objective

The broad objective of the research study was to explore mothers' experiences during the first week of the postpartum period following early hospital discharge in Mzuzu city.

Specific Objectives

1. To assess the health problems that mothers and neonates experience after early hospital discharge following childbirth.
2. To determine the type of postpartum health services that mothers and neonates receive during the first week after early discharge following childbirth.
3. To assess the type of family support mothers and neonates experience during first week of the postpartum period after early hospital discharge following

childbirth.

4. To explore mothers' views regarding early hospital discharge following childbirth.

Operational Definitions

Experience: An event or activity that leaves a lasting impression (Concise Oxford Dictionary, 2004).

Mother: A woman in relation to her child (Concise Oxford Dictionary, 2004). In this study a mother is woman who gave birth within the past one week.

Neonate: An infant from birth through the first 28 days of life (Olds, et. al., 2004).

Danger Signs: Warning signs or indicators that alert the postpartum mother to risks or complications that may develop during the postpartum period (MOH, Access, & WHO, 2008).

Postpartum Complications: The pain or discomfort from a number of unwelcome changes as the body recovers from pregnancy and labour (Fraser & Cooper, 2009).

Postpartum Period: The period following complete expulsion of the placenta and membranes to 6 weeks during which the body returns to its non -pregnant state (Fraser & Cooper, 2009). It is used interchangeably with postnatal and puerperium.

*Postpartum Care***:** Care given to a woman and her baby from the time of delivery until approximately 6 weeks of the postpartum period (MOH, Access, & WHO, 2008).

Health Problems: A state in which an individual is unable to function normally. It could be due to physical or psychological disturbances (Dictionary and Thesaurus, 2006).

Early Postpartum Hospital Discharge: Discharge of mother and neonate from the hospital within 48 hours after uncomplicated vaginal delivery (Klingner, et al., 1999). In this study early postpartum discharge refers to discharge of mother and neonate from the hospital within six to twenty-four hours after uncomplicated vaginal delivery.

CHAPTER TWO

Literature Review

Introduction

This chapter reviews literature related to mothers' experiences during the first week of the postpartum period after early hospital discharge following childbirth. There is limited literature on mothers' experiences during the first week of the postpartum period following early hospital discharge. No studies have been reported in Malawi pertaining to early hospital discharge following childbirth. However, studies that have been conducted in Western countries and Asian countries have examined the effects of early postpartum hospital discharge on maternal and neonatal health outcome. These studies have shed considerable light on the mothers' experiences following early hospital discharge. Additionally, studies on maternal and neonatal health in Malawi reveal experiences of mothers during the first week the postpartum period. The literature review that follows focuses on: the concept of early hospital discharge, health problems that mothers and neonates experience during the first week of the postpartum period, postpartum health services that mothers and neonates receive during the first week of the postpartum period, family support provided to mothers at home during the first week of the postpartum period, mothers preparation for early hospital discharge, and mothers' views on early hospital discharge following childbirth.

Early Postpartum Hospital Discharge

Early hospital discharge following childbirth refers to discharge of mother and baby within 48 hours after uncomplicated vaginal delivery (Klingner, et al., 1999). This practice was implemented in response to a shortage of hospital beds in maternity units

(Guerriero, 1943 cited by Wickham, 2005). Previously mothers were kept in the hospital longer to a maximum of seven days after uncomplicated vaginal delivery (Wickham, 2005). During this period midwives were able to assess the health status of both mothers and neonates. They were also able to educate and counsel the mothers on issues related to new roles of parenthood such as breast-feeding, baby care, and recognition of danger signs for both mother and baby (Olds, et. al., 2004). The mother was assisted with cord care, baby bath, and breast-feeding to help her develop confidence in baby care. Mothers were also having adequate time to rest in order regain strength while in hospital (Wickham, 2005). This implies that mothers were leaving the hospital after ruling out possible complications and fully equipped with knowledge and skills for self-care and that of the neonate. Some studies that have been conducted on early postpartum hospital discharge following childbirth have revealed advantages and disadvantages of this practice.

Advantages of Early Postpartum Hospital Discharge

Some studies have revealed that early hospital discharge provides opportunities for all family members to be together with the baby. Brown, et. al., (2002) in a study on early postpartum hospital discharge for healthy mothers and term infants revealed that early discharge enhances confidence in the mother and the opportunity for all family members to be together with the baby. The authors stated that this contributes to improved bonding, greater involvement of partner in newborn care, and that mothers may obtain adequate rest and sleep in their homes than hospital. Persson and Dykes, (2002) had similar findings. Persson and Dykes (2002) in a study on parents' experiences of early discharge from hospital after childbirth in Sweden revealed that parents had a sense of autonomy or self-control and physical well-being following

early hospital discharge. Parents reported that the midwives follow-up care empowers them to experience self-confidence and security after childbirth and early hospital discharge. This implies that, the mothers cope with new roles of motherhood faster during early hospital discharge than when receiving institutional care.

Other studies revealed financial implications of early hospital postpartum discharge. The study conducted by Malkin, Keeler, and Broder (2003) on postpartum length of hospital stay and newborn health revealed that early hospital discharge resulted in significant reduction in postpartum hospital care costs. The study indicated that there was significant cost saving. Similar results were reported by Brown, et. al., (2002) and Dan and Wambachi (2003). Dan and Wambachi (2003) in a study on patient satisfaction with early hospital discharge and home follow-up visits reported that the advantages of early hospital discharge include cost saving for both health facility and the individual without compromising the health and wellbeing of the mother and neonate. However, the financial benefits in settings where early postpartum hospital discharge is not combined with midwifery home follow-up visits need to be investigated.

Other studies have revealed that early hospital discharge decreases exposure of mother and neonate to nosocomial infections (Brown, et al., 2002). However, Huque (1999) in Bangladesh on the other hand found that institutional deliveries could be risky due to lack of sterilized equipment, frequent vaginal examinations, poor living conditions such as toilets and bathrooms, and poor hygiene of service providers. This implies that even with early hospital discharge the mothers are still at risk of acquiring nosocomial infections.

Furthermore, some studies reviewed the effect of early hospital discharge on

postpartum health outcome for both mother and neonates. Brown, et. al., (2002) in a study on early postnatal discharge from hospital revealed that there are no detrimental effects on postpartum health outcomes. Brooten, et. al., (2001) in a study of readmission rate of women with normal vaginal delivery revealed that less than 1% of women were readmitted. Similar results were reported by Klingner, et.al, (1999) in a study on mothers' satisfaction with one day hospital stay. However these studies were conducted in developed countries where standards of midwifery care are of quality. In addition most developed countries have well established community midwifery programmes. This implies that mothers are well looked after at home.

Disadvantages of Early Postpartum Hospital Discharge

Some studies that have been conducted on early postpartum hospital discharge have revealed that there is limited time for examination and observation of both the mother and the neonate and counseling of the mother on health promotion practices (Redshaw, 2007; Salaria, et. al., 2001). As a result mothers and neonates are discharged before many important post-birth health needs are addressed. For this reason mothers may be influenced by friends and relatives to perform harmful practices such as insertion of herbs in the vagina to reduce the size of the vagina instead of performing exercises.

Some studies have reviewed re-admission rates of mothers and neonates following early hospital discharge. Lock, Joel, and Ray (1999) in a study on higher neonatal morbidity after routine early hospital discharge found that the overall re-admission rate before implementation of the early hospital discharge guidelines was 6.7%, as compared with 11.7% after the implementation. The study further indicated that most of the re-admissions occurred within the first seven days after discharge. Similar results were reported by Hall, Simon, and smith (2000). Hall, et. al., (2000) in a study

on re-admission rate of breast-feeding infants in the first 2 weeks of life found that the re-admission rate of mothers was 2.5 % in the first week of the postpartum period and 71% visited acute care centres following early hospital discharge. Reasons for re-admission and acute care visits were infection, wound separation, bleeding, pain, and fever. Therefore, early hospital discharge without appropriate follow- up care may be dangerous.

Some studies have revealed that early postpartum hospital discharge delays detection and treatment of complications on both the infant and the mother (Brown, et. al., 2002). This is because mothers may not recognize danger signs and report to the hospital early. For instance, Lungu, Kamfosa, Hussein, and Ashwood – Smith (2001) reported that only 15% of the community recognized bleeding as a danger sign. Furthermore, the studies on postpartum length of stay and maternal and newborn health in USA revealed that the infant and maternal mortality rate was higher among newborns and mothers with short stays than for those with longer stays (Lock, et. al., 1999; WHO/United Nations Save the Children Fund (UNCEF), 2009). Main causes of deaths being PPH and maternal and neonatal sepsis. In particular most deaths were related to the delay in seeking health care with skilled personnel due to lack of necessary knowledge on danger signs and action to be taken when they develop some. This implies that most women are discharged without being informed on danger signs. As a result they may not be able to recognize complications at home consequently increasing maternal and neonatal mortality rates.

Health Problems

Maternal Postpartum Health Problems

The postpartum period is a time of joyful cerebration for the family but it is also a

time of significant physiological adaptation for the mothers which renders them vulnerable to adverse effects (Olds, et. al., 2004). Potential complications during this period include PPH; postpartum depression; sepsis; incontinence of urine; eclampsia; perineal pain; breast infections, and problems of breast feeding (MOH, Access, & WHO, 2008; Fraser & Cooper, 2009). Thus, postpartum maternal morbidities have been reported in studies from several countries.

Vallely, Ahmed, and Murray (2005) in a study on postpartum maternal morbidity requiring hospital admission during early postpartum period in Lusaka, Zambia, found that mothers were re-admitted due to pre-eclampsia (10.9%), excessive bleeding (22%), postpartum sepsis (34.8 %), infected caesarean section wound (47%), malaria (14.5%), pneumonia (6%), and infection of the reproductive tract, including infected tears and episiotomies. The majority of these admissions occurred within 24 hours after childbirth (65%). This signifies that these problems would have been identified in hospital if mothers were not discharged early.

A study that was conducted by Gözüm and Kiliç (2005) on health problems related to early hospital discharge of Turkish women indicated that, the morbidity rate of mothers in the postpartum period was high. The most prevalent health problems experienced by mothers were fatigue (86.6%), insomnia (80.4%), breast problems (engorged breast, tenderness, and pain) (71.4%), fever (35%), episiotomy pain (30%), and constipation (61.7%). Vaginal infection was reported by 14.3% of mothers. This data shows the magnitude of health problems during the postpartum period. However, some mothers may not report back to the hospital after developing a complication because they view health problems as a normal process of childbirth. Thus, Vallely, et. al., (2005) concluded that it is difficult to define, interpret, and measure postpartum

maternal morbidity based on hospital data because of the small proportion of mothers that seek medical care in developing countries when they develop a complication. Therefore, hospital data may not present a true picture of postpartum morbidity following early hospital discharge.

Other studies have revealed that mothers experience other physical conditions of lower prevalence such as haemorrhoids, constipation, urinary incontinence, sleeping disorders, and painful intercourse. Cheng, Fowles, and Walker (2006) in a study on postpartum maternal health care in the USA indicated that many mothers experienced pain in various parts of the body such as perineum (45.9%), back (54.5%), head (23%), fatigue (76%) and decreased sexual desire (52%). Similarly, McGovern, et. al., (2006) reported that mothers experienced one or a combination of other problems such as back and neck pain, constipation, haemorrhoids, sweating, and hot flashes. The study further revealed that the prevalence of headache and backache remains high over the first year of the postpartum period. This signifies that mothers experiencing such problems may not seek timely medical care as mothers may consider such conditions as minor or sensitive. However, these health problems may have a significant impact on physical, social, and psychological well-being of the mother as they may limit their daily activities for months. Consequently, the timely care for herself and neonate may be affected.

MDHS (2005) in Malawi revealed that mothers experienced heavy bleeding, infections, high blood pressure, fistula, and postpartum depression. Mzimba District was among the districts that experience higher prevalence rates of postpartum health problems such as PPH (7%), pre-eclampsia (3.5%), sepsis (3%), and depression (2.5%). This implies that the majority of mothers in Malawi also experience various

postpartum health problems which might not be recorded by health care professionals.

Lagros, Liche, Mumba, Ntebeka, and Roosmalen, (2003) in a study on postpartum health among rural Zambian women found that mothers could not spontaneously report experiencing a health problem. They further reported that abnormal signs were observed on examination such as fever, hypertension, pallor, uterine tenderness, pus like vaginal discharge, and breakdown of episiotomy or perineal tear. Firkree, et. al., (2004) in a study on health service utilization for perceived postpartum morbidity in Karachi, Pakistan reported similar results. This implies that mothers may not voluntarily give information about their health problems even when they are asked. Thus, much postpartum morbidity remains unidentified or mothers may report to the hospital when they are in a critical condition.

Some studies assessed psychological adjustment of mothers during the postpartum period following early hospital discharge. Torkan, et al., (2004), in a comparative study of mothers' quality of life after caesarean section and natural delivery, found that mode of delivery affects mothers' experiences during early postpartum period. The results revealed that the positive psychological aspects such as love, pride, authority, excitement, and strength are higher in normal delivery while regret, fear, and anxiety are higher after caesarean section. Similar results were reported by Bahadoran, Monseni, and Abed (2008); and Schroeder (2006). Schroeder (2006) found that 50% to 80% of mothers experience various psychological and mood changes such as anxiety, stress, fear, sadness, loneliness, and regret during the immediate postpartum period regardless of mode of delivery. Major causes of these problems were not being visited by family members, delay in labour, anxiety for their newborn health, and worry about other children at home. This implies that mothers' adjustment following

early hospital discharge does not correlate with mode of delivery. The significance of these findings is that mothers who are at risk of poor adjustment during the postpartum period may fail to be identified following early postpartum hospital discharge.

Neonatal Health Problems

WHO/UNICEF (2009) reported that majority of neonatal deaths are caused by conditions that may not be evident until two or more days after delivery such as infections and congenital heart diseases which may be manifested by blue or grey colour, sweat and breathlessness, lethargy, cold to touch, difficult breathing, bright green vomit, irritability, and not feeding well. Thus, some studies have investigated the effects of early hospital discharge specific to neonatal health outcome.

A study by Hall, et. al., (2000) on re-admission rates of breast-feeding infants in the first week of life revealed that, infant hospital re-admissions and mortality rate had increased and may be related to early hospital discharge. The study revealed that 4% of term neonates with less than 48 hours of hospital stay were re-admitted. The major reason for admission was jaundice (85%). Similar results were reported by Ramacher, Massey, and Adamkin (2002) and Malkin, et. al., (2003). Ramacher, Massey, and Adamkin (2002) in a study on hidden morbidity with successful early hospital discharge reported that jaundice was the major reason for re-admission of infants with early postpartum hospital discharge in USA. This implies neonates may be discharged from the hospital before the risks of developing complications have been ruled out.

In addition, Jacobs, Brambrila, and Vernon (2001) in a study on reproductive health in the postnatal period in Guatemala reported that 84 % of neonates had neonatal complications and were taken to a health facility. The most common complications were fever (65%), convulsions (77%), and difficulties in breathing (60%), difficulties

in breast-feeding (15%), common cold (43%), jaundice (4%), diarrhoea (6%), and problems with the umbilical cord (4%). Nasreen, Imam, Akter, and Ahmed (2006) in a baseline survey on safe motherhood promotion project in Narsingdi District, in Bangladesh, in (2007) had similar results that 60% of neonates experienced health problems during the immediate postpartum period. The significance of these findings is that neonates are vulnerable to postpartum neonatal complications during the early postpartum period. Unfortunately, mothers may not report back at the hospital following early hospital discharge for neonatal evaluation probably because mothers would have not recovered from effects of pregnancy, labour, and delivery. As a result, early hospital discharge without adequate preparation and appropriate follow-up care may be dangerous.

Furthermore, UNICEF (2008) indicated that neonatal mortality rates are around 20% -50% higher for the poorest households than richest quintile and 98% occur in low and middle income countries. Three-quarters of these deaths occur within the first week of the postpartum period. Major causes of deaths include infections (36%) (sepsis, pneumonia, tetanus, and diarrhoea), asphyxia (36%), and prematurity (27%). These conditions can be successfully treated if they are promptly diagnosed. Unfortunately, the majority of neonates face these health problems when they are at home without the support of a skilled heath professional following early hospital discharge. As a result there is delay in initiating appropriate treatment.

Other studies have revealed that mothers interpret normal infant behaviours as health problems (UNICEF, 2008; Sines, et. al., 2007). Common normal infant behaviours reported by mothers as health problems include: sleeping a lot, making noise while breathing, wriggles around, having a lot of mucus, bowel motion after

every feed or once a week, frequent spills of vomits, crying, transient rashes, and birth marks. This shows that mothers may lack knowledge on neonatal health problems requiring health professionals' intervention.

Postpartum Health Services

Postpartum health services have been viewed by midwives as an essential component of the maternity services because most maternal and neonatal deaths occur during the first seven days after childbirth (MOH, 2005; WHO, 2004). Postpartum care services are needed to encourage preventive health behaviours and practices such as warming the infant. The services also increase the likelihood that potentially life threatening complications in both mother and neonate are detected, referred, and treated as early as possible. Postpartum care health services can be provided at the health facility, through home visits by health workers or through a combination of care in the health facilities and at home (Sines, et. al., 2007).

Health Facility Postpartum Health Services

Evidence has shown that effective postpartum care by skilled personnel can reduce maternal and neonatal morbidity (Lawn & Kerber, 2007). However, few studies have examined utilization of postpartum health services during the first week of the postpartum period and the results reveal a low utilization rate. MDHS (2005) in Malawi, indicated that only (2.8%) of mothers received postpartum care from the third to the seventh day of the postpartum period. This shows that mothers are not monitored how they are adapting physically and psychologically during this crucial postpartum period. The low utilization of postpartum health services may be due to factors related to availability of health facilities, quality of health services, knowledge

on postpartum health services, and cultural beliefs related to the postpartum period such as seclusion of mother and baby for a period of one week to one month (MDHS, 2005).

In most developing countries access to postpartum health services is limited due to scarcity of and unevenly distributed health facilities (Sector Wide Approach (SWAp), 2008). For instance, in Malawi, distance from the residential areas to health facilities has been identified as a factor that influences utilization of postpartum health services during the postpartum period (MDHS, 2005). Essential health package (EHP) in Malawi estimated that 46% of the population live within 5 kilometres of a health facility and 20% live within 25 kilometres of a hospital (EHP, 2004).This is of particular importance as mothers are discharged from the hospital within six to twenty-four hours after delivery. Long distances, coupled with lack of transport money, and poor road network may create difficulties for mothers to access and utilize health services when they develop complications immediately after early hospital discharge. For instance, Lungu, et. al., (2001) reported that the average transport time to the hospital for a Malawian woman exceeds four hours and 88% walk to the nearest facility. Similar results were reported by Dharkl, et. al., (2007) and Castro, Camperol, Hernåndez, and Langer (2000). Dharkal, et. al., (2007) in a study on utilization of postpartum care among rural women in Nepal found that an increasing distance between residents and health facility, lack of transport, and good roads were commonly thought to decrease the utilization of postpartum health services. Similarly, Castro, et. al., (2000) in Mexico in a study on maternal mortality reported that the main barrier to access emergency maternal health care services was lack of transport from their homes to the health facility. This shows that most mothers may not be able to

report back at the hospital following early hospital discharge when they develop a complication. As a result mothers may seek help from close relatives, traditional healers, and health care providers last, thereby contributing to high maternal and neonatal morbidity and mortality rates.

MDHS (2005) in Malawi reported that education plays an important role in determining who attend scheduled postpartum check-ups. Women with secondary or higher education are more likely to go for postpartum check-up within 42 days after delivery (54%) compared to women with no education (29%). Similar results were reported by Gyimah, Takyi, and Addai (2005). Gyimah, et. al., (2005) reported that levels of education have a positive effect on women's use of health services. The significance of these findings is that education empowers mothers' health seeking behaviour.

Poverty has been widely documented, in the literature, as a determinant of health-seeking behaviour. Nabukera, et. al., (2006), in a study on use of postpartum health services in rural Uganda, revealed that lack of transport money, fear that doctors may prescribe expensive medication were barriers to utilization of postpartum health services. MDHS (2005) in Malawi also indicated that women coming from the highest wealth quintile are more likely to go for postpartum check-ups (50%) compared to women coming from lowest wealth quintiles (27%). Additionally, the MDHS (2005) estimated that 52.4% of the population live below the poverty line, and 57. 9% of these are women. These findings signify that mothers may not seek health services, even when they know that they have a life-threatening condition, because of financial problems. Thus mothers residing close to St. John's Hospital in Mzuzu may find problems to access health services since the hospital is a Christian Health Association

of Malawi (CHAM) health facility, where services are not free. However, the Service Level Agreement (SLA) between CHAM and government that maternal and neonatal health services should be offered for free in CHAM hospitals may improve the postpartum health service utilization rate.

Furthermore, some studies have revealed that utilization of postpartum health services is associated with the quality of health care being provided to the mothers. Mothers perception of quality of services include: competence of health workers; attitude of health workers; availability of equipment, supplies, and essential drugs; availability of health providers; reputation of health care providers and communication skills (Lomoro, Ehiri, Qian, & Tang, 2002; Nabukera, et. al., 2006; Declercq, Sakala, Corry, Applebaum, & Risher, 2002). Declercq, et. al., (2002) in a study on Listening to mothers found that about one third of mothers who attended the routine one and six-weeks postpartum check-up felt that common health problems that they face were not addressed except for vaginal examination and contraceptive education. Lomoro, et. al., (2002) reported that mothers were not satisfied with quality of postpartum care because midwives provided incorrect and unreliable information, checked baby's weight only, and gave limited instructions. Nabukera, et. al., (2006) reported that mothers complained that health care providers were rude, they were in a hurry, and difficult to be contacted in time of need during the immediate postpartum period in the hospital. These experiences may act as a barrier for women to return to the hospital for postpartum care services. Mazia, et. al., (2009) on the other hand found that when health workers are trained in promoting and providing early postpartum care services, there is 20 fold increase in the number of visits to the health clinic within the first three days after childbirth. Therefore, improved communication at family, community, and

health care level may improve utilization of postpartum health services.

On the other hand, some mothers in similar studies were satisfied with postpartum health services (Lomoro, et. Al., 2002; Fikree, et. al., 2004; Nabukera, et. al., 2006). Mothers reported that evidence of their baby's weight gain during the scheduled one and six weeks postpartum check up visits provided reassurance of the baby's health and well-being (Fikree, et. al., 2004). Therefore, there is need to improve health providers' knowledge, skills, and attitude in order to improve quality of postpartum health services.

Other studies have revealed that despite the benefits of the postpartum care services, most mothers and newborns do not seek postpartum health care services from a skilled health care provider. Lagros, et. al., (2003) found that majority of mothers who reported having experienced health problems did not seek health services from a health facility. Thirty- two percent took pain killers, 15% used hot compresses, 12 % used African medicine, 9% sought advice from a relative, and 29% sought a professional health workers advice. Similar results were reported by Firkree, et. al., 2004; Parvin, et. al., (2004); and Jacobs, et.al., (2001). Parvin, et.al., (2004) reported that mothers bought medicines from nearby groceries for treatment of postpartum problems while Firkree, et. al., (2004) reported that mothers sought traditional healers advice first before utilizing hospital health services.

Knowledge of health problems during the postpartum period and decision making powers also influence mothers' utilization of health care facilities. Fikree, et.al., (2004), in a study on health service utilization, for perceived postpartum morbidity, among poor women in Karachi, reported that mothers' postpartum health seeking behaviour depends on their perception of severity of the health problems that they have

developed. The study revealed that mothers seek out-patient or in-patient postpartum health services when they develop high fever with chills because it is considered dangerous for ones' health, while backache is a considered normal and mothers are not supposed to tell anyone about it. These findings reflect beliefs that postpartum period health problems may be taken as normal because they occur as a result of the normal process of labour and delivery and sensitive (Nabukera, et. al., 2004). Thus, lack of knowledge of the physiology of postpartum health problems may result in delay in seeking health care during the first week of the postpartum period, consequently leading to increased maternal and neonatal mortality.

Furthermore, Fikree, et. al., (2004), in the same study, reported that mothers perceived that they could decide to take a sick child to a hospital but they required permission from husbands to travel to a clinic. Similar results were reported by WHO/UNICEF (2009) that many women in developing countries have no say in their health care needs. In Mali, Burkina-Faso, Nigeria, and Malawi, more than 70% of women reported that their husbands alone made decisions regarding their health care. This shows that knowledge of postpartum health problems is not the core determinant of postpartum health service utilization.

Lack of knowledge of postpartum health services has been reported in some studies to influence utilization of health services during the first week postpartum. The studies have revealed that, health workers do not inform mothers that they need a check-up at a given time or need to be visited in their homes (Nabukera, et. al., 2004; Lomoro, et. al., (2002). Similar results were reported in Malawi. MDHS (2005) reported that women fail to go back to the hospital following early hospital discharge for check-up at one and six-weeks of the postpartum period. Reasons for failure to access the health

service were reported as due to lack of knowledge of the postnatal services (16%), long distance to the hospital (60 %), cost of treatment (62 %), and cost of transport (55%). This implies that women are not properly followed to monitor how they are adapting physically and psychologically during period.

Other studies have revealed that residence determines mother's utilization of postpartum health services. Bhatia and Clelanda (2004) reported that utilization rates of postpartum check-ups are positively and significantly associated with urban residence, educational status, and place of delivery. Gyimah, et. al., (2005) and MICS (2006) also reported similar results. MICS (2006) report that the percentage of women receiving postpartum care in urban areas in Malawi within the first seven days after delivery was high (5.6%) compared to women in the rural areas (4%). These findings explain that mothers in the urban areas of Malawi, Mzuzu city inclusive, receive postpartum care during the immediate postpartum period. However, the percentage of mothers who receive postpartum care is low despite having easy access to health facilities in the urban areas.

Home Follow-up Postpartum Health Services

Home follow-up of mothers and neonates within the first week is very useful as a number of maternal and neonatal deaths can be prevented by detecting postpartum health problems early. It is also a period when most problems of the mother and the neonate occur. Lawn, et. al., (2005) reported that 75% of newborn deaths occur in the first week of the postpartum period therefore, home postpartum check-up could be ideal within two to three days after birth. Studies that have been conducted in Bangladesh, India, and Pakistan have shown that home visits reduced deaths of newborns by 30-61%. The visits improved coverage of newborn care practices such as

early initiation of breast-feeding, exclusive breast-feeding, skin to skin contact, delayed bathing, attention to hygiene such as hand washing with soap and water, and cleaning umbilical cord. The studies further revealed that home visits helped families in identifying maternal and newborn health problems early and in dealing with constraints to seeking health professional's postpartum care within the first week of the postpartum period following early hospital discharge (WHO/ UNICEF, 2009). This implies that mothers will receive prompt treatment early during home follow-up and thereby reduce maternal and neonatal mortality.

Some studies have examined the appropriate time for home visits by health professionals following early hospital discharge. Studies indicate that home visits within two to three days of life improve maternal and newborn survival. The studies revealed that newborns who were visited within 48 hours after birth had lower subsequent morbidity and mortality than those visited later (Lawn, et.al., 2005; Kumar, et. al., 2008). However, mothers and their newborns in most developing countries are not visited following early hospital discharge until they present themselves at scheduled one-week postpartum check-up visit at the hospital. Therefore, there are missed opportunities to identify and treat their problems early.

WHO (2004) recommends that home visits be conducted by skilled health workers in order to provide preventive and curative care. However, in many settings this is not feasible due to shortage of skilled health workers, lack of transport, and increased workload that does not allow health professionals to make timely and repeated home visits. Pilot studies that have been conducted in Bangladesh, Nepal, Malawi, India, and Ethiopia revealed that the use of Community Health Workers, Female Community Health Volunteers, Health Surveillance Assistants (HSA), and Health Extension

Workers to provide home based maternal and neonatal care after appropriate training was effective (WHO/UNICEF, 2009; Fort, et. al., 2008). The study revealed that early recognition of severe illness and administration of oral antibiotics by these trained community health workers and early referral to the health facility for provision of daily antibiotic injection substantially improved access to treatment. This implies postpartum home visits can still be implemented despite shortage of skilled health workers.

Some studies have examined the cost of home follow-up visits compared to hospital based care. Cheng, et. al., (2006) in a study on postpartum health care in USA reported that although initial cost of home visits is higher than hospital based care, home visits by midwives are cost effective as there is reduction in maternal and neonatal re-admission rates. Similar reports were reported by Malkin, et.al., (2003). This implies that, it may be difficult for resource poor countries to implement the home follow-up postpartum care.

A study on newborn length of hospital stay and health care utilization in Minnesota revealed that early home follow-up within the first week of the postpartum period resulted in completion of immunizations, reduced urgent or emergency department visits, and re-admission rates for both mothers and neonates (Madlon-Kay, Defor, & Egerter, 2003). However, only 12.4% of all the mothers who were discharged early (zero to one day) received home visits. This implies that health professionals find difficulties in implementing home follow-up postpartum care despite having the home follow-up policy in place. This signifies that it may also be difficult in developing countries to conduct home follow-up due to critical shortage of health professionals and lack of material and financial resources.

Family Support

Postpartum period is a transitional period and potentially stressful when mothers have to face their new roles and duties as mothers while dealing with various changes in their bodies (Fraser & Cooper, 2009). New mothers face challenges to cope with personal, parental, marital, and family demands following childbirth (Wickham, 2005).Thus every society recognises that new mothers need both emotional support and practical assistance during the postpartum period for their physical, emotional, and social well-being. Studies that have been carried out have shown that social support is one of the main dimensions associated with the physical, emotional, and social well-being of mothers and neonates (WHO, 2004).

Bahadoran, et. al., (2008) in a study on mothers' experiences found that mothers find it difficult to cope with the new responsibilities in this period of life. Mothers expressed that it was difficult to take care of themselves and the baby especially when they were experiencing painful breasts, had problems with the stitches, and bleeding. The study further revealed that mothers alluded to the presence of family members who assisted with baby care. Similar results were reported by Parvin, et. al., (2004); Cheng, et. al., (2007); Nasreen, et. al., (2007); and Lagros et al., (2003). Lagros, et. al., (2003) in a study on postpartum health among rural Zambian women found that mothers resumed household activities such as cooking and grinding maize within two weeks of the postpartum period. Twenty-seven percent of women resumed sexual relations with their partners within two weeks. As such, women felt that there was no time for resting following early hospital discharge. Therefore, early hospital discharge should be well planned in advance so that the mother will have a family member readily available for support. The communities also need to be oriented on the need for

rest during the postpartum period to prevent complications that may develop due to strain.

A study on the transition to fatherhood and the role of formal and informal support structures during the postpartum period in Canada by Montigny, Lacharite, and Amyot (2006) indicated that mothers found their husbands as the most important source of support during the first week of the postpartum period. Mothers reported that husbands paid for medical services and nutrition supplementation, offered practical help, and accompanied them to health services for consultation. Similar results were also reported by Chhay (2008) in a study on factors influencing postpartum check-ups among mothers in Cambodia. The study revealed that husbands with secondary school education encouraged their wives to receive postpartum check-ups from skilled health personnel. On the other hand, MDHS (2005) revealed that 44% of fathers in Malawi reported that their wives did not get postnatal care after discharge because they did not think it is necessary, and 32% reported lack of knowledge. This implies that when husbands have knowledge of postpartum care, they become more supportive during the postpartum period, and thereby influencing the mothers' experiences during this period. Therefore, midwives need to involve partners during education and counselling on postpartum health issues in order to improve participation of mothers in postpartum care.

Furthermore, some studies conducted in Vietnam and Canada indicated that grandmothers from the maternal side were more supportive in giving advice and information regarding postpartum period. The studies reported that grandmothers were giving information on nutrition, prevention of infection, keeping baby warm and dry, and helping mothers with household chores (Thi, Pasandarntorn, & Rauyajin, 2002;

Montigny, et. al., 2006). Similar results were reported in studies done in China and Bangladesh on traditional practices during the postpartum period. The studies revealed that new mothers are not allowed to do housework during the first month after delivery because it is assumed that they are weak and hard work could lead to back pain and prolapsed uterus in the future (Raven, Chen, Tolhust, & Garner, 2007; Nasreen, et. al., 2006). As a result, mothers-in-law do the household chores. However, this practice is declining in most societies, possibly due to increase in nuclear families as a result of urbanisation. Consequently, mothers may not cope well with the demands of the newborn if there are no relatives to help them with baby care.

On the other hand, Firkree, et. al., (2004) found that grandmothers prepare special herbal vaginal pessaries to facilitate uterine shrinkage, tightening of vaginal walls and facilitate uterine bleeding to remove impurities. Similar results were reported by Thi, et. al., (2002); Raven, et. al., 2007; and Nasreen, et. al., 2006. Thi, et. al., (2002), in a study on traditional postpartum practices among Vietnamese mothers in Anthi District, Hung Yen province, found that mothers-in-law were advising daughters-in-law to restrict intake of food during the postpartum period. Postpartum mothers were not allowed to eat spicy food, fatty foods, and cold food like fruit because they cause diarrhoea, and influence the quality of milk. These practices can predispose mothers to puerperal sepsis, postpartum haemorrhage, and nutritional health problems. The significance of these findings is that dependence on significant others during the postpartum period may predispose mothers to harmful practices which may endanger their lives and that of the neonate. Thus new mothers who have inadequate knowledge on postpartum care may be influenced by the relatives and end up with postpartum health problems during the postpartum period.

Khadduri, et. al., (2008), in a study on household knowledge and practices of newborn and maternal health in Haripur district, Pakistan, found that traditional birth attendants (TBAs), friends, work colleagues, and support groups provide support to mothers during the postpartum period. The study revealed that the TBAs visit new mothers for a period of 10 to 30 days during the postpartum period to massage the woman to relieve delivery pain, massage breasts for milk flow, give emotional support, wash clothes, cook, and help with other household chores. Similar results were reported by Montigny, et. al., (2006) and Firkree, et. al., (2004). This shows that social support groups facilitate stress reduction, thereby reducing incidences of postpartum psychosis resulting from poor coping mechanisms.

Other studies h0ave revealed that health professionals such as midwives and paediatricians are also supportive during postpartum period. A study in Zambia on postpartum health among rural women found that mothers who were educated by midwives in their homes on neonatal health were able to identify danger signs and take action more frequently (Lagros, et. al., 2003). Similarly, Persson and Dykes (2002), in a study of parents' experiences of early hospital discharge from hospital after childbirth in Sweden found that community midwives were more supportive during the postpartum period. The parents reported that the midwife's home visits and telephone calls gave them a sense of security and self-confidence after childbirth following early hospital discharge. These findings show the vital role played by midwives in helping mothers to cope with the demands of motherhood.

Preparation for Early Postpartum Hospital Discharge

Preparation of the mother for early hospital discharge is done in order to assist the

mother to cope with self-care needs for herself and the baby and to identify problems that may occur (Fraser & Cooper, 2009; MOH, Access, & WHO, 2008). The preparation includes education and counselling on health promotion practices and recognition of danger signs. Health promotion practices include maintenance of good nutrition for mother and neonate, baby care, cord care, rest and sleep, perineal exercises, personal hygiene, neonatal immunizations, and family planning (Lawn & Kerber, 2007; MOH, Access, & WHO, 2008). Danger signs for the mother include; excessive bleeding; foul smelling vaginal discharge; fever with or without chills; severe abdominal pain; excessive tiredness or breathlessness; swollen hands, face, and legs with severe headaches or blurred vision; painful and engorged breasts, sore or cracked, and bleeding nipples. Danger signs for the baby include; convulsions; movement only when stimulated or no movement even with stimulation; poor feeding; fast breathing (more than 60 breaths per minute), grunting, or severe chest in-drawing; fever (above 38°C); low body temperature (below 35.5°C); very small baby (less than 1500 grams or born more than two months early), and bleeding on the umbilical cord (Lawn & Kerber, 2007; MOH, Access, & WHO, 2008). However, the midwife provides this information within 24 hours of childbirth while the mother is still exhausted with labour pains. Thus, a trial study done in Nepal on effects of health education for mothers on infant care and family planning revealed that one to one counselling of mothers by health workers had no significant effect on mother's knowledge and practices of child care or infant health outcomes (Bolam, et al., 1999). Olds, et. al., (2004) also argued that the first 24 hours after birth is the taking in phase and is not conducive for learning. This implies that health education given during this time may not be effective because the mothers may not retain the information as they

are still recovering from trauma of childbirth.

A review of results from safe motherhood promotion project in Bangladesh revealed that respondents had adequate knowledge on the care to be provided to the neonate during the postpartum period such as wrapping the baby to maintain body temperature (77%), breastfeeding (77%), Kangaroo mother care (KMC) (9%), cord care (33%), and immunization (7%) (Jacobs, et. al., 2001). Interestingly, only 15 % of mothers reported having exclusively breastfed their babies and 15% introduced other foods at one month and 20 % at 2 months in the same study. Similar results were reported by Milligan, Push, Bronner, and Spotz, (2009) in a study on breastfeeding duration among low income women had similar results that there is a high rate (34%) of formula feeding following early hospital discharge. These findings show that mothers may lack skills to perform health promotion practices. Lack of home follow-up visits by midwives and community support group may have contributed to this lack of skill.

Furthermore, Valdez, Seims, Mijoni, Leburg, and Johnson, (2001) in a baseline survey for Umoyo network in Malawi on the other hand indicated that mothers reported that they were applying alcohol (24%), leaves or flowers (12%), water or soda (5%), breast milk (4%), and dung (3%) on the umbilical stump. The significance of these findings is that mothers have inadequate knowledge on cord care. These findings may correlate with early discharge due to inadequate time to counsel the mother on health promotion practices.

Nasreen, et al., (2006) in a study on safe motherhood promotion project in Narsingdi District found that mothers had knowledge on maternal care following delivery such as providing nutritious food (90%) and maintaining cleanliness (99%).

However, they were not aware of the need for adequate rest (17%), avoiding heavy work (13 %), and when to resume sexual activity (36%). The significance of these findings is that mothers may resume household chores early which may put mother at risk of developing complications such as uterine prolapse due to strain. Additionally, ovulation can begin within four weeks after delivery (Fraser & Cooper, 2009). Therefore, failure to provide mothers with information on when to resume sexual activity may be detrimental to the mother as this may result in early pregnancy.

A study on hidden morbidity with successful early discharge in USA, on the other hand revealed that mothers lacked confidence to recognize normal infant behaviours from those that could be early signs of problems such as infections, dehydration, and jaundice (Radmcher, et. al., 2002). Similar results were reported by Brown, et al., (2002); and Bhatia and Cleland's (2004). Bhatia and Cleland's (2004) in a study on determinants of maternal care in southern India found that 40% of postpartum maternal deaths occurred at home while 8.7 % occurred on the way to the hospital following early hospital discharge. This shows that mothers fail to recognize danger signs and seek health care professionals early. Thus, mothers may seek medical care when the neonate is critically ill. This signifies that mothers require adequate counselling and education on issues that address their health concerns during the postpartum period in order to reduce maternal and neonatal mortality following early postpartum hospital discharge.

The other aspect of mothers' preparation for early hospital discharge is psychological care in order to assist the mother to cope with the transition to motherhood. Yonkers, Ramin, and Rush (2001), in a study on onset and persistence of postpartum depression in an inner city maternal health clinic system, found that

mothers are prone to psychological health problems during the postpartum period. This is usually due to one or a combination of issues, including coping with breast-feeding, fear of body changes after delivery, financial pressure, being deserted by a partner, isolation, lack of family or social support, and no experience of a maternal role model. This implies that adequate preparation of mothers for postpartum period is essential for positive psychological adjustment following early hospital discharge.

Preparation for discharge also focuses on physical examination of the mother and neonate to ensure that mother and neonate goes home in good health condition. MDHS (2005) revealed that 50.8% of neonates had physical examination by midwives before discharge and were also encouraged to attend the six weeks scheduled postpartum check-up visit. On the other hand a safe motherhood study (1998) in Malawi as reported by MOH (2005) revealed that 65 % of mothers did not have their blood pressure checked before discharge. This implies that not all neonates and mothers are assessed thoroughly before discharge. Thus, failure to perform physical assessment means that neonates and mothers are not adequately evaluated and certain health problems may not be identified before early hospital discharge. Therefore, early hospital discharge may put the mother at risk because the mother will go home to take care of herself without adequate preparation.

Mothers' Views on Early Hospital Discharge

Malawi adopted and implemented the practice of early discharge in the 1990s. The practice of early hospital discharge means that mothers and neonates may be discharged before all assessments and preparation for self-care at home has been completed. Studies that evaluated mothers' satisfaction with early hospital discharge have revealed that some mothers are satisfied while others are not.

Klingner, et.al., (1999), in a study on mothers' satisfaction with one-day hospital stay for routine delivery at Irwin Hospital, revealed that 71% of mothers with one-day and 37% of mothers with two-days stay reported that their stay was too short and they would prefer to stay longer with the next child. Reasons for dissatisfaction included inability to get enough rest at home and concern that they will miss information and attention from knowledgeable persons. Despite their dissatisfaction with the one-day stay, mothers reported that they were prepared to take care of their infants as did mothers with two days' stay. This implies that early hospital discharge with adequate maternal preparation may provide sufficient knowledge for mothers' adaptation during the postpartum period.

A study on Thai women's perceptions of early postpartum hospital discharge in Australia revealed that when early hospital discharge is optional, women would choose to recover in the hospital (Rice, et. al., 1999). The mothers stated that they valued rest and sleep that they may not get at home due to other children and household responsibilities. Similar results were reported by Winterburn & Fraser (2000) in USA that mothers were worried that they would miss the information the nurses provide; they needed sleep and rest, comfort and time alone; and help, support, and protection from nurses. This implies that mothers' feelings about early hospital discharge correlate with their expectations of postpartum care and their responsibilities.

Some studies have shown that mothers were satisfied with early postpartum hospital discharge. Studies done in the UK and Sweden revealed that 83% of mothers ranked 24 hour-hospital stay as being a most important service if it is accompanied by a follow-up through telephone calls or home visits by midwives and availability of a home worker. Mothers felt that early discharge enables them to feel a sense of self

control and autonomy, thereby being able to take responsibility for the new baby (Dana & Wambachi, 2000; Persson & Dykes, 2002). Only 17 % of women stated that they feared early hospital discharge because they did not had support at home.These findings demonstrate that mothers need support during the postpartum period regardless of their level of satisfaction with early hospital discharge.

Similarly, another study on early postnatal hospital discharge for health mothers and term infants indicated that mothers were satisfied with early hospital discharge because they were more relaxed in their homes, family bonding was improved, partners become more involved in neonatal care and a home care system was available (Brown, et al., 2002). Ninety percent of the mothers further reported that they would participate again in this program and would recommend it to their friends. The significance of these findings is that family bonding can be achieved more easily if the family is together in their home with the partner's participation in the care for the neonate.

On the other hand, Rice, et. al., (1999), in a study on Thai women's perceptions of early hospital postpartum discharge in Australia, reported that mothers who opted to go home early after vaginal delivery, expressed concern that they were not seen by midwives until the day of discharge when they were taught how to breastfeed. Similar results were reported by Valdez, et. al., (2001) and Lungu, et. al., (2001). This implies that, the quality of postpartum care and bad attitude of health workers may make mothers to opt or early hospital discharge.

Summary

The literature reviewed reveals that major gaps exist with respect to the full impact

of early hospital discharge on maternal and neonatal health outcomes in both developed and developing countries. Studies on the effects of early hospital discharge on maternal and neonatal health outcome were inconsistent with some studies which revealed that there is no detrimental effect, while others revealed high morbidity. Few studies that have examined mothers' experiences with early hospital discharge suggest that women may develop physical as well as psychological health concerns during the postpartum period. Studies have further revealed that health promotion practices, family support, and utilization postpartum health services are vital for health outcome of both the mother and neonate. Additionally, studies have revealed both mothers satisfaction and dissatisfaction with early hospital discharge. However, the studies do not examine the mothers' experiences during the first week of the postpartum period, which is the most threatening time of the postpartum period. The significant implication of early hospital discharge therefore is that mothers are discharged before many important postpartum health needs are addressed. As such, mothers may be influenced by relatives and friends to go into harmful practices that may put them at risk of infection. Therefore, early hospital discharge may not be safe in developing countries where midwifery care is of low quality and the ties of the extended family are still strong. Therefore, this study provides insight into mothers' experiences during the first week of the postpartum period following early hospital discharge. The knowledge gained will assist health care professionals to plan and implement postpartum health services that will meet mothers concerns, whether they are recovering at home or in hospital.

CHAPTER THREE

Methodology

Introduction

This chapter describes the methodological techniques that were used in this study. The chapter will describe the study design, setting, population, sampling method, sample size, data collection, data management and analysis, ethical consideration, and study trustworthiness

Research Design

Research design refers to the overall plan for addressing a research question including specifications for enhancing the study's integrity (Polit, & Beck, 2010). In this study a descriptive phenomenological qualitative research design was used to explore the mother's experiences during the first week of the postpartum period following early hospital discharge.

Qualitative research is a subjective approach used to describe life experiences and give them meaning (Burns & Grove, 2005). A descriptive phenomenological qualitative research design, on the other hand, is an approach used to explore and understand people's everyday life experiences as a means of uncovering meaning and generating understanding about certain things (Polit & Beck, 2010). The method is used to investigate the phenomenon that needs further clarity either because there is little published or what is published needs to be described in more depth (Speziale & Carpenter, 2007; p.92). The goal of this method therefore, is to document and interpret fully and in totality what is being studied. Thus, this researcher chose this method because little is known about mothers' experiences with early hospital discharge

during the first week of the postpartum period in Malawi. The use of this method enabled the researcher to study mothers' experiences during the first week of the postpartum period as mothers described their everyday life.

Setting

Setting describes the physical location where individuals of interest live, experience life, and where data collection for the study takes place (Speziale & Carpenter, 2007, p.28; Polit & Beck, 2010, p.568). The researcher in this study collected the data in the respondent's homes. This was done to maintain the natural setting where the experiences occurred. The setting for this study was Mzuzu City which is in Mzimba District, in the Northern Region of Malawi (See Appendices J & K). The city has a population of 128,432 with 29,539 women of child bearing age (National Statistical Office, 2008). The City has a total of three health facilities that are currently providing maternal and neonatal health services, namely, Mzuzu Health Centre (MZHC), St. Johns Hospital, and MZCH. These facilities are about 5 to 10 kilometres apart. Clients' major method of transport includes bicycles, minibuses, and taxis; those who cannot afford these modes of transport walk. Additionally, these health facilities practice early hospital discharge following childbirth. On average, over 200 mothers are discharged per month from each of the health facility (Mzuzu Central Hospital maternity annual report, 2009; Mzuzu Health Centre and St. John's Hospital Maternity Register Book for 2008/2009 fiscal year). The area was chosen because experience while working at MZCH showed that 3.5% of mothers and 16% of neonates were reporting back to the hospital within the first week of the postpartum period with maternal and neonatal health problems. Additionally, Mzimba District is one of the districts with the lowest utilization rate of postnatal care (2.1%) within seven days

after delivery (MICS, 2006).

Target Population

Target population refers to the entire population in which a researcher is interested and to which the researcher would like to generalize the results (Polit & Beck, 2010; p.568). The target population for the study were all mothers residing in Mzuzu City who gave birth at MZCH, Mzuzu Health Centre, and St. John's hospital within the previous six weeks and were discharged within 24 hours after an uncomplicated vaginal delivery. These mothers were chosen because they had experienced early postpartum hospital discharge. Additionally, the experience was still fresh in their mind and they could describe it with clarity.

Sampling Method

Sampling refers to the selection of a group of people that are representative of the population being studied (Burns & Grove, 2005). In this study, purposive sampling method was used to identify the mothers. Purposive sampling method refers to a nonprobability sampling method in which the researcher selects participants based on personal judgement about who will be most informative (Polit & Beck, 2010). This method allows the researcher to use her knowledge to identify a specific group of people who exhibit the characteristics of the phenomenon which is being investigated (Burn & Grove, 2005). In this study, the researcher identified the respondents at the hospital when they were attending their six-week scheduled postpartum check-up visit, under-five clinic, and postpartum family clinic. The researcher asked the mothers about the period that they had spent in hospital after uncomplicated vaginal childbirth and also reviewed the mothers' personal health passport book to identify the date of

delivery, the date of discharge, and the mode of delivery. This was done to ascertain if the mother was meeting the criteria for participating in the study. Mothers who were discharged within 24 hours after uncomplicated vaginal delivery were chosen. The researcher obtained physical addresses and telephone numbers from the participants and followed them up in their homes.

Sample Size

A sample is a part of the target population selected in such a way that the individuals in the sample represent the characteristics of the target population (Burn & Grove, 2005). The sample consisted of 26 mothers who were discharged from the hospital within 24 hours after uncomplicated vaginal delivery. The sample size was achieved through data saturation. Data saturation refers to a point when information being shared by the participants has been shared before by other participants (LoBiondo- Wood, 2005).

Inclusion and exclusion Criteria

Inclusion criteria refer to the criteria that specify the characteristics that delimit the study population (Polit & Beck, 2010). The criteria identify persons who qualify as members of the study population. Exclusion criteria on the other hand refer to the criteria specifying characteristics that a study population does not have (Polit & Beck, 2010). In this study, the researcher chose those mothers who were discharged within 24 hours after uncomplicated vaginal delivery, having a live child, being in postpartum period (within six weeks after delivery), willing to participate in the study, and being able to express themselves (having no speech or hearing problems). Mothers who could not understand Chichewa or English were excluded from the study. This

was done to facilitate effective communication and understanding between the researcher and the participants. Consequently, participants were able to share rich data in a clear and concise manner. Mothers, who delivered their babies at traditional birth attendants or at home, were also excluded from this study. This is because they did not have the experiences of early hospital discharge following childbirth.

Data Collection

A personal face to face in-depth interview method of data collection was used in this study. Interview refers to a data collection method in which an interviewer asks questions of a participant either face to face, by telephone, or over the internet (Polit & Beck, 2010). An open-ended or in-depth interview is an unstructured or semi-structured conversation with a purpose of providing participants with the opportunity to fully describe their experiences. This method involves use of audiotape, and verbatim transcription of data, and use of interview guide to ensure that all areas of interest are covered during interviews (Speziale & Carpenter, 2007).

Data Collection Instrument

A data collection instrument refers to a device used to collect data (Polit & Beck, 2010). In this study an interview guide was used to collect data. An interview guide refers to a written topic guide to ensure that all areas of interest in the study are covered (Polit & Beck, 2010). The guide was developed (See Appendix A) by the researcher in English and then translated into Chichewa. The guide consisted of demographic data for participant's identification and open-ended questions in order to obtain in greater depth of the information regarding mothers' experiences after early hospital discharge (Speziale & Carpenter, 2007). The demographic data was included

to determine age, level of education, occupation, tribe, parity, and religion of the sample population. This information is important because it can influence mothers' experiences following early hospital discharge after childbirth. Open-ended questions focused on the objectives of the study as follows: health problems, postpartum health services, social support, and mothers' views regarding early hospital discharge. Prior to data collection, the interview guide was reviewed and refined by the supervisor, experts in the field of maternal and neonatal health, and experts in research methodology to ensure trustworthiness of the study (Polit & Beck, 2010).

Phases of Data Collection

Phase I-pre-testing the data collection instrument.

Pre-testing the data collection instrument means checking the accuracy of data collection tool (Polit & Beck, 2010). Its purpose is to determine the length of time it takes to administer the entire instrument package, identify questions that are misinterpreted, determine the sequencing of questions, and if the measures yield data with sufficient variability and to ensure if the tape recorder was working satisfactorily. In this study, the interview guide was pre-tested with three participants with similar characteristics to those in the main study but not included in the main study. The participants were identified at the hospital when they attended the scheduled six-week postpartum check-up visit, six weeks under-five clinic, and six weeks postpartum family planning clinic. Participants were readily available and were willing to participate in the study. Midwives, health surveillance assistants and student midwives in the health facilities were also helping in identifying the participants especially at the under-five, and family planning clinics. Mothers were asked individually the period

they spent in hospital before discharge after childbirth. The researcher then checked the date of delivery, date of discharge, and mode of delivery in the health passport book to ascertain if the mother was meeting the criteria for participating in the study. Mothers were also asked if they could understand Chichewa or English. Those mothers who met the criteria and were willing to participate in the study were individually invited into an office where the researcher read out an introductory information letter describing the study (see appendix C) in more detail. The mothers were then asked to sign a consent form (see appendix E) when they indicated willingness to participate in the study prior to interviews. Data collection was through face to face in- depth interviews using an interview guide. The interviews were in the form of a conversation where the role of the interviewer was that of an active listener and facilitator. The interview lasted over 30 to 45 minutes in one sitting with each participant in order to provide enough time for the participant to think and give a response. During interviews, the narrative data was audiotape recorded while the researcher was taking note of non-verbal cues. Data was transcribed verbatim and analysed within 24 hours of conducting the interviews. Following the results of the pilot study, questions were modified and rearranged.

Phase II – actual data collection procedure for the research study.

Participants were identified following the same phase one procedure. However, when the mothers indicated willingness to participate in the study the researcher obtained physical addresses, telephone numbers, and followed them up in their homes later at an agreed upon time. Interviews were conducted face to face in the houses of the participants, individually to maintain privacy and confidentiality, and allow the participant to be more comfortable and be able to give more information. Twenty-six

mothers were interviewed. The decision to stop at 26 was based on the fact that the data became saturated.

Data Management and Analysis

Data management refers to the activities involved in the preparation for the data analysis (Polit & Beck, 2010). In this study, the audio-tape recorded narrative data was transcribed verbatim (hand written) in Chichewa by the researcher and then translated into English after each interview. This was done to make adjustments along the process of data collection, test emerging themes, and categorise against subsequent data after each interview. Administrative files for keeping the transcripts were set up. Interview guides containing each participant's demographic data were put together with both Chichewa and English transcripts of the narrative data, field notes, and consent forms in the file. Transcripts were arranged by participant's identification code numbers. The files and the tape recorder were locked in the drawers of the researcher's study table and were only accessible to the researcher. At the end of data collection, the researcher typed the comprehensive write-ups, including field notes for each participant using personal computer which was only accessible to the researcher. Then the typed transcripts were printed and put in a file for analysis.

Qualitative data analysis refers to working with data, organizing it, breaking it into manageable units, synthesise it, searching for patterns, discovering what is important and what to be learned, and deciding what to tell others (Polit & Beck, 2010). The significance of data analysis in qualitative studies is to discover themes and links among the themes in order to understand the lived experiences.

Demographic data was analysed manually using descriptive statistics. Mean, range, frequency, and percentages were calculated for age, level of education, occupation,

tribe, and religion as indicated in chapter four on presentation of findings. The narrative data was analysed using Colaizzi`s (1978) content analysis technique, which is a method of analysing written, verbal, and visual communication messages (Elo & Kyangäs, 2007; Speziale & Carpenter, 2007). The analysis went on as followings:

1. The researcher read through all the data to obtain a general sense of the information and determined meaning of each significant statement. Each meaningful statement was assigned a code and the codes were written in the margins while reading the transcript.
2. The researcher reviewed the codes for similarities. The codes carrying similar meaning were isolated and grouped under one category or theme. A general description or definition of the theme was given, and each theme was named using the characteristic words of the content under the theme. The codes under themes with similar events and incidents were grouped into sub-themes. Then experienced midwives (two), the supervisor, and one research expert were given the typed transcripts and they independently analyzed the data and verified the themes with those of the researcher in order to ensure trustworthiness of the results. There was 90% agreement between the experts and the researcher with respect to emerging themes and sub-themes.
3. The researcher wrote exhaustive descriptions of the lived experiences. The themes were described and participant's expressive language was incorporated in the presentation of results in order to capture the total meaning of the themes.

Trustworthiness

Trustworthiness refers to the process of evaluating the quality of data and findings. Trustworthiness was evaluated based on the scientific rigor criteria used in qualitative

methodology identified by Lincoln and Guba (1985) which assesses the credibility, dependability, confirmability, and transferability of the findings (Polit & Beck, 2010).

Credibility refers to the confidence in the truth of the findings and interpretation of them as judged by participants and others within the discipline (LoBiondo- Wood, 2005). In this study, mothers who were discharged within 24 hours after childbirth and were within six weeks of the postpartum period were selected. Therefore the sample was capable of providing rich data because they had experienced early postpartum hospital discharge and their memories of the experience were still fresh. The researcher was asking the participants to clarify certain issues in case of inconsistencies during data collection, in order to develop an in-depth understanding of the phenomenon understudy. While data was collected by the researcher herself, investigator triangulation was achieved by allowing the supervisor, experienced midwives, and research experts to independently analyze the data from the interviews and verify the themes with those of the researcher. In-depth interviews were lasting over 30 to 45 minutes in order to provide adequate time for participants to thick and give a response and to building trust and rapport with the participants. As a result the participants were free to express themselves.

Dependability refers to stability of the data over time and over conditions (Polit & Beck, 2010). In this study dependability was achieved by analyzing the data following the Collaize's content analysis steps. The supervisor, experienced midwives, and research experts independently analyzed the data using the same steps and came up with comparable themes and subtheme with those of the researcher (90% agreement). This is a reliable method and has been used by many researchers in nursing, sociology, psychology, and business (Neundorf, 2002 as cited by Elo &

Kyangäs, 2007).

Confirmability refers to objectivity and that data reflect accurately the experiences of the participants and that there would be agreement between two or more independent people about the data's relevance and meaning (Polit and Beck, 2010). It also ensures neutrality of the data such that the researcher is able to distinguish personal values from those of the participants. This was achieved by tape-recording all the words spoken by the participant and the researcher in order to distinguish the participant's data from interviewer's views. An interview guide was used in order to direct the interviews so that the researcher should not be influenced by what has been said by participant. The interviews were in the form of a conversation where the role of the interviewer was that of an active listener and facilitator to allow participants to give detailed information of their experiences. An already prepared theory was not used in order to be open minded about what may be discovered. This was done because theories have pre-conceptions that can limit the scope of study (Speziale & Carpenter, 2007). The exemplars were selected to represent the participant's expressive language and incorporated in the report. However, follow-up of participants to confirm the findings was not done due to limited time.

Transferability describes how the results will be applicable and meaningful to individuals not involved in the research (Speziale & Carpenter, 2007). In this study transferability was achieved by terminating data collection when saturation was reached. Thus the results may be transferable to all mothers who are within the immediate postpartum period in Mzuzu City only since the study was not conducted in the whole Malawi. However, sufficient descriptive data in the report of the findings has been provided so that consumers interested to make a transfer can evaluate the

applicability of the data to other contexts.

Ethical Considerations

Ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations to the study participants (Polit & Beck, 2010). In this study, ethical issues were ensured by obtaining approval from Kamuzu College of Nursing Research and Publication Committee (appendix G) and the College of Medicine Research and Ethical Committee (COMREC) (appendix H) prior to data collection to ensure participant protection. Permission to conduct the study in Mzuzu City was obtained from the Chief Executive Officer of Mzuzu City Assembly and the District Health Officer for Mzimba North (appendix I and J respectively). An information letter (Appendix C) was formulated to explain the purpose of the study to the participants. The letter explained the risks, benefits, and confidentiality issues. Information regarding the investigator, including address and phone number, was included on the information letter. Assurances were given that health care services would not be affected by respondents' withdrawal or refusal to participate in the study.

Written consents were obtained from participants prior to interviews and after explaining the purpose, benefits, and risks of the study in the language respondents could understand. The risks to the participants were few. The only physical risk was fatigue related to the time required to complete the interview. The respondents were informed that there would be no immediate benefits for participating in the study, but that the results would generate knowledge which would be used to improve the quality of postpartum health services following early hospital discharge after childbirth. In order to enable them to make informed consent to continue with the interviews,

participants were also informed that the interview would be tape recorded. Confidentiality of participants was also maintained by coding identification code numbers on the interview guide and audiotapes. Their identity was not linked to their responses when presenting data. Interviews were conducted individually in the house of each participant to maintain privacy and confidentiality. The research findings that contained information about participant were only accessible to authorised persons, such as the research supervisor. Participants were also informed that if their husbands or friends or family members objected to their participation in the study, they would not be interviewed to avoid family conflicts. However, none was asked not to participate by family members.

Dissemination of Results

Dissemination of results refers to communication of research findings so that the results should contribute evidence to nursing practice (Polit & Beck, 2010). The results of this study will be communicated verbally to the academic staff at Kamuzu College of Nursing during research seminars. A copy of the report will be placed in Kamuzu College of Nursing library. Other copies will be sent to MOH, Reproductive Health Unit, COMREC, Mzimba North District Health Office, and Mzuzu City Assembly. Parts of the report will be published in professional journals.

Summary

A descriptive phenomenological qualitative research design was used to explore the mothers' experiences with early hospital discharge during the first week of the postpartum period. Twenty-six participants were interviewed following an interview guide which was comprised of demographic data and open-ended questions. The

interview was focusing on health problems mothers and neonates experienced, postpartum health services, family social support, and their views on the practice of early postpartum hospital discharge. Tape recorded interviews were reviewed and analysed following Collaizz's content analysis technique. The themes that emerged from the analysis are presented in chapter four.

CHAPTER FOUR

Findings

Introduction

This study was conducted in Mzuzu city in the Northern Region of Malawi from 15th March to 1st April 2010. The study was carried out to explore mothers' experiences during the first week of the postpartum period following early hospital discharge after childbirth. The experiences were explored by following the objectives of the study which focused on: health problems that mothers and neonates experienced; postpartum health services that mothers and neonates received; the type of support that mothers received at home; and mothers views regarding early hospital discharge following childbirth. This chapter presents the data obtained from the interviews and observations made by the researcher during the interviews. The findings were categorised into themes and sub-themes and have been presented under the following themes: characteristics of participants; health problems experienced; utilization of postpartum health services; social support that mothers received during the postpartum period; preparation for early hospital discharge by midwives; and mothers' views on early hospital discharge following childbirth.

Characteristics of Participants

A total of 26 mothers who had given birth within the six weeks prior to the interview participated in this study. The mean length of hospital stay was 13 hours. Demographic data of the participants included age, marital status, educational status, employment status, ethnicity, religion, parity and place of delivery. Table 1 shows the frequency and percentage distribution of the social demographic data of the participants. The participants' age ranged from 15 to 40 years with a mean age of 24

years. Fifty-four percent of the participants reported that they attained secondary education, 92% were married, 62% were Tumbuka by tribe, 31% belonged to Church of Central African Presbyterian (CCAP), and 54% were housewives. The study further revealed that 50% of their spouses attained secondary education and 46% were businessmen. Fifty-eight percent of the participants were multiparas with an average number of 2 children per participant. Fifty-eight percent of participants delivered their babies at MZHC.

Table I. *Characteristics of the Participants (N=26)*

Variable	Frequency	Percentage
Age		
Below 20	6	23
21-30	16	62
31 -40	4	15
Marital status		
Married	24	92
Single	2	8
Ethnicity		
Tumbuka	18	69
Chewa	3	11
Nkhonde	2	8
Lambiya	2	8
Ngoni	1	4
Religion		
CCAP	8	31
Assemblies of God	4	15
Other	14	54
Educational Status		
Mother	14	54
Secondary Education	12	46
Primary Education		
Spouse		
Tertiary Education	6	25
Secondary Education	12	50
Primary Education	6	25
Occupation		
Mother		
Housewife	14	54
Business	8	31
Labourers	3	11
Student	1	4
Spouse		
Business	11	46
Skilled Workers	6	25
Labourers	7	29

Table 1. *Characteristics of Participants (N=26) Continued*

Variable	Frequency	Percentage
Parity		
Primipara	10	38
Multipara	15	58
Grandmultipara	1	4
Place of delivery		
Mzuzu Health centre	15	58
Mzuzu Central Hospital	7	27
St. John's Hospital	4	15

Health Problems

The major theme which emerged from the narratives of participants' experiences was health problems that mothers and neonates experienced during the first week of the postpartum period. Mothers reported that they or their neonates experienced one or more health problems during the first week of the postpartum period. The problems identified were grouped into sub-themes of expected maternal postpartum health problems, unexpected maternal postpartum health problems, expected neonatal health problems (normal infant behaviour), and unexpected neonatal postpartum health problems (unusual infant behaviour).

Expected Maternal Postpartum Health Problems

Expected maternal health problems included all normal anticipated complaints of the postpartum mother which can be attributed to effects of labour and delivery. These problems included abdominal pains, backache, painful legs and pelvis, vulva swelling, perineal pain, painful stitches, and general body weakness.

Abdominal pains.

The majority of the participants reported that they experienced abdominal pains. Of these, the majority perceived abdominal pains as normal while a few participants

feeling abdominal pains...I thought that it was normal...but what surprised me was that, I started having severe abdominal pains and backache for three days as if I was in labour." Mothers who reported that they were feeling severe abdominal pains associated the pain with retained products of conception. A few participants indicated that abdominal pains were due to the effects of childbirth and that the pain was coming from where the baby was lying. However, the majority of participants identified myths related to abdominal pains following childbirth. Participants reported that they were feeling abdominal pains due to the presence of umbilical cord on the baby and because the baby was still in seclusion for one week. These beliefs were common among the Tumbuka, Ngonde, Ngoni, and Lambiya tribes. One participant reported: "I had the abdominal pain before the umbilical cord fell off on the baby after that everything was okay**..."**

Additionally, the majority of mothers reported that they consulted their husbands, mothers, mothers-in-law, and neighbours for explanation or advice on the health problem they experienced, while a few reported that they did not consult anyone. The majority were advised that the problems they were experiencing were normal. Participants were reassured by their mothers and neighbours that they had experienced the same problems during the birth of their children, and that the problems resolved on their own. A few participants were advised to take remedies such as coca-cola, chombe tea, and to hold the abdominal muscles with a *chitenje* (cloth) to relieve pain. One mother reported: "some people told me to boil the chombe tea leaves and drink the water." The majority were advised that abdominal pains would cease when the umbilical cord on the baby fell off or when the baby was taken out of seclusion.

A few stated that their husbands bought pain killers from nearby groceries/shops or

they were taking Panadol that they were given at the hospital on discharge. One mother who consulted the husband reported: “I told my husband that I was feeling severe abdominal pains. He told me that they are *vinyalu* (effects of childbirth) and he bought Brufen...after taking Brufen I felt better.” A small proportion was advised to go to the hospital by their mothers, husbands, and neighbours because they felt that the pain was caused by retained products of conception. One mother reported: “I informed my mother that I was feeling severe abdominal pains she decided that we should go to the hospital.” A few of the participants reported that they decided to consult the health professionals about their health problem during the scheduled one-week postpartum check-up visit.

General body pains and weakness.

The results showed that a small proportion of participants reported having experienced backache, painful legs and pelvis, vulva swelling, perineal pain, painful stitches, and general body weakness the first three to four days after discharge. A large proportion of participants who experienced these problems also reported having experienced abdominal pains or excessive vaginal bleeding. None of the participants perceived these as serious health problems. One participant narrated: “I was just feeling lower abdominal pains ... (pointing in the waist), pelvic pain, and backache, since the day I was discharged from the hospital. I was failing to walk.”

The majority of participants had correct knowledge on causes of general body pains and weakness. Mothers stated that they were experiencing the problems because of the effects of childbirth or pushing and that the pain was coming from where the baby was lying. There were no myths or beliefs related to the cause of these problems. The majority of participants reported that they did not consult anyone because they felt that

it was normal, while a few consulted their mothers, sisters-in-marriage, husbands, and neighbours about the health problems. With regard to treatment, a few reported that they were massaging with hot water. A few participants who experienced perineal pain and painful stitches reported that they were cleaning the perineum with warm salty water as advised by nurses. A large proportion of mothers who sought health services reported that their mothers or husbands made the decision to seek health services. A small proportion made their own decision to seek health services. Participants stated that in certain situations, they do not need to consult their husbands to seek health services.

Unexpected maternal postpartum health problems

Unexpected maternal postpartum health problems included all health concerns that mothers are not expected to experience during the typical postpartum period. These problems included health problems directly related to labour and delivery such as excessive bleeding, severe abdominal pains, and breast problems and general medical problems.

Excessive bleeding and severe abdominal pains

A small proportion of the participants reported that they bled a lot during the first four days after hospital discharge. Mothers reported that big clots were coming out of the vagina; they were failing to walk; experiencing severe abdominal pains; feeling dizzy; and were having headaches. One participant narrated:

> I delivered normally...the bleeding was controlled and I was confident to go home. While at home I noted that I was bleeding heavily, big clots were coming out and we went back to the hospital the following day in the morning.

The majority of mothers who experienced this problem stated that they experienced heavy, smelly, blackish or brownish vaginal discharge and lower abdominal pains during the second week of postpartum period. The majority mentioned that excessive vaginal bleeding was due to the effect of childbirth and retained products of conception. There were no myths mentioned in relation to the cause of vaginal bleeding and severe abdominal pains.

Many participants who experienced this problem consulted their mothers, mothers-in-law, sisters-in-marriage, neighbours, and husbands while few others did not consult anyone because they felt it was normal. Most participants reported having been advised that it was a normal experience and that the problem would resolve on its own. Mothers reported that they were advised by their family members that they would get well with massaging alone. One participant narrated:

> I told my sister in-marriage that I was bleeding a lot. She told me that I should wait may be the bleeding will stop after some days... She was massaging me... now the vaginal discharge smells and it is brownish.

A small proportion said they had been advised to report to the hospital immediately while a few stated that they had consulted the health professional during one-week scheduled postpartum check-up visit. There were no remedies reported to alleviate excessive bleeding.

A few of the participants reported that they experienced minimal bleeding during the postpartum period. Participants reported that they bled for fewer days than what they considered normal. One participant stated that “normally the bleeding takes ten days” and was surprised after this delivery that the bleeding took four days only. Participants associated reduced vaginal bleeding following childbirth with effects of

family planning methods. There were no reported remedies tried for the problem.

Several mothers reported that their mothers or mothers-in-law made the decision on their behalf to seek health services when they experienced the severe abdominal pains and excessive bleeding. A few stated that they visited the hospital for consultation on their own because they were either worried that there may be retained products of conception or that they may lose a lot of blood.

Breast problems.

Participants also reported having experienced breast problems such as breast engorgement and nipple sores. The participants explained that they started experiencing the problems the third to fourth day after childbirth. One participant said, "I developed nipple sores and I have been having problems with breast-feeding. The sores started on the fourth day after childbirth...up to now I am still having the sores."

When asked on the causes of breast problems, all mothers who experienced these problems stated that breast engorgement was caused by the baby *kugeyera* (letting air out after breastfeeding) to the breast or sleeping over the breast during the night. A few who experienced nipple sores associated them with first-time breast-feeding. Participants further reported that they consulted their mothers, husbands, and neighbours about the problem. Mothers reported that they were advised to continue breast-feeding and to visit the hospital. A few participants reported having used soda and salt to clean the nipple sores. All mothers who experienced breast problems reported that they continued feeding the baby from the affected breast till the problem was resolved. When asked about decision-making to seek health services, a few reported that they made their own decision or the seriousness of the problem, the neighbours, and their husbands motivated them seek health services.

General medical problems.

General maternal medical problems during the first week of the postpartum period include health problems not related to labour and delivery such as malaria, cough, and headache. One participants developed blisters on the right side of the face, which were diagnosed as shingles. The participant narrated having feelings as if there was sand in the eyes, failing to see, and headache. When asked about the cause of the problems, the participants reported mosquito bite as the cause of malaria. The participant who developed blisters could not tell the cause. No remedies were reported having been used to alleviate the problems. When asked about decision- making to seek health services, the participants mentioned consultation with the husband, the seriousness of the problem, and advice from neighbours as factors involved in decision making.

Expected Neonatal Health Problems

The majority of mothers reported normal infant behaviours such as crying as a problem during the first week of the postpartum period. Mothers reported that their babies were crying because of abdominal pains. One mother whose neonate was crying narrated:

> The baby was crying a lot...maybe it was because of abdominal pain. I don't know…because when she was crying, it was as if something had bitten him. I really don't know whether the problem was due to abdominal pains or not.

Mothers reported that their neonates were experiencing abdominal pains because of failure to let air out after breast-feeding and that intestines were winding up as a result of feeding. A few of the participants had myths and beliefs associated with crying. Participants said that their babies were crying with abdominal pains because the

umbilical cord had not fallen off. A few more reported that they have been told that a baby born during the night cries during the night and sleeps during the day.

Many participants reported having consulted their husbands, neighbours, friends, mothers-in-law, and their mothers about their neonate's health problem. A few reported that they had not consulted anyone. The majority reported having been advised that it was a normal experience of a neonate and they should give the neonate Gripe Water or Phillips of Magnesium to alleviate the problem. One mother, a primpara narrated: "My friends…advised me to buy Gripe Water or Phillips of Magnesium." A few said they had been advised to visit the hospital and had therefore decided to consult the health professional during the scheduled one-week postpartum check-up visit.

Unexpected Neonatal Health Problems

Several of the participants narrated that their infants suffered from typical infections. It was also noted that neonates experienced more than one health problem. These problems were categorised into gastrointestinal tract (GIT), skin, eye, and general health problems.

Gastrointestinal tract problems.

A few participants reported that their neonates had experienced health problems related to the gastrointestinal tract (GIT) system. Mothers reported that their neonates experienced abdominal distension, oral thrush, passing bloody stools, vomiting and being tongue tied. Oral thrush, abdominal distension, and passing bloody stools could be signs of neonatal infection. When asked the causes of these problems, most of the mothers could not identify any. However, a few reported that they were told that

vomiting was due to not letting air out after breast-feeding. An abdominal distension was reported to be caused by *nyongozi* (worms). One mother explained: "The abdomen was much distended and shiny. My mother said the baby was crying because he had *nyongozi* (worms)".

Furthermore, the majority reported that they had consulted their neighbours, their mothers, and their husbands about the neonate's health problem. Many of the mothers reported that they had been advised to visit the hospital and a small proportion said they had been advised to visit a traditional healer for management of distended abdomen and tongue tie. A few reported having been advised to give their neonates Phillips of Magnesium and Gripe Water to alleviate abdominal distension and the passage of bloody stools respectively. One mother whose neonate had oral thrush was advised that "a young goat should gloat into the baby's mouth." Lack of knowledge on causes of neonate's health problems was also reported by a few as being a motivating factor to seek health services. Many mothers reported that they had made own decisions to visit a health facility for consultation about the health problem.

Eye infection.

Many of the participants reported that their neonates had experienced discharging eyes the first week of the postpartum period following early hospital discharge. All participants who had experienced this problem lacked knowledge on possible causes of the problem. Many participants reported myths and beliefs connected to the causes of eye infection, such as taking too much salt during pregnancy. One participant narrated: "I was told by neighbours that my baby is having eye discharge because I was taking too much salt during pregnancy." Mothers narrated that they consulted their husbands, their mothers, and neighbours about the neonate's problem. Many of the mothers

reported that they had been advised to report to the hospital, and a small proportion said they had been advised to apply breast milk to the baby's eyes or blow into the eyes while chewing salt. One mother narrated: "I was advised by my mother to apply breast milk in the baby's eyes. I was not given any medication at the hospital."

The majority of the mothers reported that they made own decision to seek health services when the neonate was sick. Mothers stated that they stay with the baby most of the time and they notice the change in the baby's health status earlier than their husbands. Therefore, they made decisions to seek health services. One mother narrated: "I took the decisions to take the baby to the hospital because I spend more time with the children...I know the seriousness of the child's condition...whether there is need to take him to the hospital or not."

Skin infection.

A few mothers reported that their neonates developed blisters like scald which later developed pus, sores (septic spots) and the neonates had fever. One mother narrated: **"**The baby developed some small blisters like scalds the whole body. They started the same week that I was discharged...just three days after discharge... The sores were on the head and the whole body and they were producing pus." One mother narrated that the neonate developed the boil on the right breast within the first week of the postpartum period. A small proportion of participants complained that their neonates developed body rash. Most mothers could not tell the causes of their neonate's health problems, with the exception of those whose babies had developed body rash. Mothers explained that their neonates experienced body rash due to heat.

When mothers consulted their own mothers, mothers-in-laws, neighbours, and husbands, the majority reported having been advised to seek medical health services,

while a few said they had been advised to seek faith healers' services. There were no reported remedies to alleviate the problem. However, a mother whose neonate had had an abscess reported that the husband squeezed out the pus after the baby was discharged from the hospital. Furthermore, most mothers reported that they had made their own decision after observing the baby's condition to seek health services. A few reported that the decision had been made in consultation with their husbands, neighbours, mothers, and mothers-in-law.

General health problems.

General health problems that mothers reported included cough and sneezing. Several participants reported that the baby had started coughing and sneezing before they were discharged. One participant narrated: "The baby had a cough which started at the hospital...The baby was just sneezing... I did not tell the doctor at the hospital and I have not given him any medication…because I thought it would stop on its own." With regard to knowledge on causes of such problems, mothers reported that they did not know the causes. However, a few reported that cough and sneezing were acquired from their mothers during pregnancy. Mothers reported having consulted their neighbours, sisters-in- marriage, mothers, and husbands about their neonate's problems. A few reported that they had been advised to report to the hospital about the neonate's health. When asked about decision-making to seek health services, the majority reported that they had made their own decision or in consultation with their husband or their mothers.

Utilization of Health Services

All participants who reported having experienced health problems or neonatal

health problems were asked questions regarding utilization of health services. The narratives were categorized into type of health services they approached, treatment they received, satisfaction with health services, and failure to utilize health services.

Type of Health Services

The results revealed that mothers utilized a variety of health services. Most mothers reported having utilized hospital services such as out-patient (OPD) services, in-patient services, and the scheduled one-week postpartum check-up visit. A few said they had visited traditional healers and faith healers.

Out-patient services.

OPD postpartum health services were utilized immediately after discharge due to excessive vaginal bleeding and severe abdominal pains. The majority of mothers stated that they visited the hospital the following day after discharge due to excessive bleeding and severe abdominal pains. One participant reported: "I was feeling severe abdominal pains... I went back to the hospital...The nurse examined my abdomen and she said the uterus is returning to its non-pregnant state."

The majority of participants who had presented a complaint of abdominal pains reported that they had been given Panadol or Brufen. A few who had presented complaints of excessive vaginal bleeding reported that they had not been given any treatment. One of the participants who had utilized the health services due to excessive bleeding said that she was informed that the bleeding was from a tear but nothing was done. The mother reported that she was reassured that the bleeding would stop. All participants who utilized out-patient services reported having been counseled that their problems were normal experiences during the postpartum period.

With regard to neonatal health problems, most participants reported having utilized outpatient hospital health services when their neonates suffered from oral thrush, conjunctivitis, body sores, abdominal pains, vomiting, and passing bloody stools. A few participants whose neonates had experienced body sores reported that they had been treated with topical drugs and Amoxicillin syrup. The majority who had complained of oral thrush, body sores (septic spots), and conjunctivitis reported that they had not been given any medication because there were no drugs at the hospital. A mother whose baby was passing bloody stools reported having been reassured by the nurse that it was normal. A few were referred for inpatient services.

In-patient services.

The study revealed that only one mother utilized in-patient services for unexpected maternal medical problems. The mother she was admitted in the hospital because of shingles. The mother could not tell specific drugs that were given at the hospital but reported having been given eye ointments, topical drugs and injections.

With regard to neonatal care, one participant reported that the neonate had received in- patient services due to an abscess. The mother narrated: "I went to Mzuzu Central Hospital because the baby had an abscess. I was admitted for two days. On the third day, I was discharged and advised to observe the baby at home". The mother reported that the neonate had been discharged before full recovery. When asked what type of treatment the neonate had received, the mother only mentioned injection and drip.

One-week scheduled postpartum check-up visit.

Nearly all mothers in this study attended the scheduled one-week postpartum check-up visit. Participants reported that they had been told by nurses during hospital

discharge that they should attend the one-week postpartum check-up. The majority of mothers stated that they attended the one-week postpartum check-up so that the nurses should assess the baby's umbilicus. One mother narrated: "I went for check-up at one-week scheduled postpartum check-up visit so that the nurses should examine the baby because sometimes the umbilicus can have problems."

The majority of the participants who experienced health problems and did not attend postpartum outpatient services reported that they did not present their problems during the one-week scheduled postpartum check-up visit because they felt that it was normal. A few stated that they were advised by family members and neighbours that the problem would resolve with time. One participant who experienced excessive bleeding and did not present the problem at outpatient department or during the one-week scheduled postpartum visit explained:

> I did not tell the nurse about my problem during the check-up visit because I felt that it is normal... It happens after delivery...but the bleeding continued for one week and some days... the vaginal discharge is now producing bad smell, and I am feeling abdominal pains.

A few of the participants reported that they presented their health problems to midwives during the visit. A few participants that presented the complaints of abdominal pains stated that they were reassured or given treatment such as Brufen or no treatment. Mothers who believed that they did not bleed enough during the immediate postpartum period due to the effect of family planning methods also consulted the nurses. Mothers reported that they were reassured that it is a normal experience. One mother who reported abnormal vaginal discharge complained that no physical examination had been done to detect the problem. The mother narrated:

> When I went to the hospital for check up...I told the nurses that I am having watery vaginal discharge...She asked me if the discharge is bloody, and I said no, but watery...It seems the nurse was busy...because I was not examined, vaginal examination was not done…check-up was not done!

However, the majority of mothers reported that they were asked if they were bleeding excessively during visit. A few reported that the abdomen was examined, their weight was checked and blood pressure was measured. A small proportion of the participants reported that the nurses had sent them away and they did not receive the services. Mothers complained that they were not given the next date of appointment but they were told to come back anytime they felt it necessary.

Regarding the neonate, most mothers reported that their neonates were checked on the umbilicus and the eyes, and they were weighed during scheduled one-week postpartum check-up visit. The majority of participants reported that they consulted the midwife about the neonate's problems. A few mentioned that their neonates were given treatment for conjunctivitis while others were reassured that the problem was normal. The majority of participants who complained that their neonates experienced abdominal pains during the first week of postpartum period did not consult the midwives during scheduled one-week postpartum check-up visit. Reasons for not consulting the midwife were that it was a normal experience.

Traditional and faith healer.

Besides utilization of hospital health services, a few of the participants sought help from traditional and faith healers. Mothers reported that they sought health services from traditional healers and faith healers after being dissatisfied with hospital services. One participant's mother decided to take the infant to a traditional healer for treatment

of a tongue tie. The mother stated that the tongue tie was released using traditional medicine. The mother narrated: “The nurse did not recognize the tongue tie... My mother identified the problem... I don’t know what was going to happen if my mother was not here. We went home (village) the same week to visit the traditional healer”. A small proportion of the participants reported that they had utilized faith healers services. One participant narrated that after prayers, the neonate got healed of an abscess.

Satisfaction with Services

The majority of mothers who utilized hospital health services expressed satisfaction with the health services. Mothers stated that they got the treatment that they wanted. On the other hand, a small proportion of mothers reported that they were dissatisfied with health services that they received. A few reported that they were dissatisfied because they were turned away from the hospital without receiving the services. The participants also lamented that the nurses were not examining clients thoroughly to identify health problems and give them appropriate treatment. Many reported that they were not given any treatment when they visited the health facility with health problems. A few participants narrated that they were advised to buy drugs. One participant explained, **“**At the hospital the doctor prescribed some medicine... I was told that there were no drugs and I was advised to buy from pharmacy in town.”

Furthermore, a few others were dissatisfied because the neonate was discharged from the hospital before full recovery. One mother narrated that the baby was sick and the discharge order was accepted because there was nothing they could say. A few more reported that they were not given advice or treatment when they reported their health problem or their neonate’s. Participants complained that the nurses just said the

problem would resolve, without explaining what should be done to alleviate the problem. As such, mothers got advice from neighbours. One mother explained:

> I told the nurse about the baby's eye problem and she said I should not worry, it will subside...I was not given any medication...Here at home, I was advised by my friends to blow into the babies eyes while chewing salt.

Failure to Utilize Health Services

The study further revealed that most mothers did not utilise health services immediately they noticed the signs of the problem either in themselves or the neonate. The majority reported that they were waiting for the one-week scheduled postpartum check-up visit to discuss their concerns. Reasons for opting to wait for the one-week scheduled postpartum check-up visit included to avoid making a lot of trips and the belief that the problem was minor. A few mothers reported that they failed to seek health services because their family members had told them that symptoms such as excessive bleeding, abdominal pains, and general body pains were "normal experiences during the postpartum period."

Most participants did not seek health services because of their beliefs or myths related to health problems during the postpartum period. Mothers reported that they took the advice from their neighbours that abdominal pains either for the mother or neonate stops after falling off of the umbilical cord and indeed it happened. A few did not seek health services because they were told by nurses during discharge that "the problem was normal it would resolve on its own." A few participants stated they delayed to seek health services because they had no money for transport. They reported that they had to walk to and from the health centre for the baby to get the services.

Social Support

This theme relates to the source of support, the type of support being provided and traditional practices during the postpartum period.

Sources of Support

The majority of mothers reported that they received support from their mothers, mothers-in- law, husbands, and neighbours during the first week of the postpartum period. One participant explained:

> My husband was supporting me. He was providing me with water for bathing myself and the baby and with cooking before going to work. He was coming back from work around 11:00 am to prepare lunch and water for bathing. In the evening he was coming home around 5:00 pm to prepare supper and water for bathing. He did this for a period of one month.

A few mentioned children, aunts, brothers, sisters-in-law, sisters, nieces, and sisters-in-marriage. A small proportion reported being responsible for their own self-care and that of the neonate.

Type of Support Provided

Most participants were assisted with cooking and preparation of water for bathing because they were not allowed to use fire during the postpartum period, according to their tradition. A few were assisted with cooking to allow the mother to rest for a period of one week. Furthermore, most participants reported that they were assisted with household chores such as sweeping, mopping, drawing water, and cleaning plates. In relation to financial support, a large proportion of mothers reported that their husbands, their mothers, mothers-in-law, and aunts provided money to buy food,

drugs, groceries, and clothes for the baby. Regarding baby care, the majority reported that they were assisted with bathing and soothing the baby when they failed to do so themselves. A few reported that their own mothers were teaching them how to bath the baby, keep the baby warm, and washing nappies. One participant narrated:

> My mother came from the village to look after me. My mother was cooking, preparing bathing water for me and the baby…She was also helping me with baby care, especially during the night when the baby was crying and I have failed to console him.

Despite having a person providing support, all mothers reported that they were responsible for providing their personal hygiene and for providing baby care. The majority of participants reported that they were responsible for washing nappies and clothes for the baby, the husband, and themselves. A few reported that they were assisted with bathing of the baby until the cord fell off because they were afraid to traumatize the baby. Mothers who had persons providing support were asked about the duration for the support. The majority of mothers who were the Tumbuka, Nkhonde, Lambiya, and Ngoni reported that they were assisted with cooking and preparing bath water for a period of one month. A few mentioned a period of four days to one week. The majority participants who were assisted by neighbours stated that they received support for short periods because their neighbours have other responsibilities in their homes. One participant narrated: "My neighbour supported me for four days only… No one came from home to assist me. I was forcing myself to perform other duties like drawing water, washing, and cleaning the home."

Traditional Practices during Postpartum Period

Majority of mothers reported that there were persons supporting them during

postpartum period because of their traditional practices. Traditional postpartum practices of not using fire, seclusion of the baby and abstinence from sexual intercourse were frequently mentioned by the participants. All participants mentioned these practices but duration depended on ethnicity.

Mothers should not use fire.

The majority of mothers belonging to the Tumbuka, Lambiya, Nkhonde, and Ngoni tribes reported that they were not cooking (use fire) for a period of one month. Mothers reported that "traditionally, a new mother does not cook for a period of one month after childbirth…They say that if you cook, males including your husband, will have swollen legs." A few, reported that mothers were unclean because of the bleeding, therefore they were not supposed to cook. The Chewa mothers on the other hand, reported that they were not cooking the first week of postpartum period because they were tired. However, a few of the participants pointed out that they do not see the significance of these practices because they have seen that nothing happens to men whose wives use fire immediately after giving birth.

Seclusion.

Besides abstaining from using fire, a few mothers reported that their babies were secluded for a period of one week. Babies were allowed to be taken outside only when the umbilical cord had fallen off and when the hair was shaved. These practices were shared by all participants regardless of ethnic background. One reasons for secluding the baby was to avoid catching cold. However, most respondents could not tell the reasons why the neonate should be secluded.

Sexual abstinence.

The majority of mothers reported that according to tradition, they are supposed to abstain from sexual activity for a period of six months. As a result they were sleeping with their mothers, or mothers-in-law, or were using their own mat in the same bedroom with their husband. Participants could not identify the reason why they should abstain for that long.

Preparation for Early Hospital Discharge

The narrations on preparation for early hospital discharge were categorized into education and counseling, maternal and neonatal health assessment and treatment.

Education and Counselling

When asked about knowledge of postpartum health promotion practices and danger signs during postpartum period, the majority indicated that they were counseled on maternal and neonatal care and recognition of danger signs for both mothers and neonates.

Maternal and neonatal care.

Most mothers reported that they were counseled on perineal care and to report back at the hospital for the scheduled one-week postpartum check-up visit. A few reported having been counseled on personal hygiene, family planning, resumption of sexual activity, nutrition, resting, prevention of diseases such as Human Immuno-deficiency Virus (HIV) and Acquired Immuno-deficiency Syndrome (AIDS), malaria, and diarrhoea. One mother narrated: “I was advised to clean the perineum with salty water, breast-feeding frequently, bathe the baby twice a day... eat well-balanced diet such as vegetables ...meat and fruits.” The majority of the participants reported that they were

counseled on cord care, breast-feeding, positioning and attachment of the baby to the breast, and maintaining infant hygiene. A few of the participants mentioned introduction of other foods in addition to breast milk at six months, starting under-five clinic at six weeks, immunization, changing nappies frequently, and keeping the baby warm. A small proportion reported that they were not given any information regarding baby care. Majority of participants also reported that they were told by the midwives to visit the hospital again for one and six-weeks scheduled postpartum check-up visit.

Recognition of danger signs.

Mothers were probed to find out if they were counseled on danger signs during the postpartum period. The majority reported that they were not counseled about danger signs during the postpartum period. A few that they were taught about danger signs mentioned severe bleeding, anemia, fainting, breast problems, malaria, weakness, dizziness, diarrhoea, abdominal pains, abnormal vaginal discharge, and fever. A few stated that they had forgotten some of the things they were taught. One mother who had not been given any information on postpartum care narrated: "During discharge, I was not taught anything about danger signs or how to take care of myself at home. I don't even know the health problems that mothers or the neonate can suffer during the postpartum period."

With regard to counseling on neonatal care, mothers were asked about danger signs that indicate the need for urgent care for the neonate during the postpartum period. The results showed that the majority were not counseled about danger signs for the neonate. A few mentioned fever, convulsions, failure to breast-feed, vomiting, redness on the umbilicus, diarrhoea, and crying. One mother narrated: "The nurse said that if the child is sick there are a lot of things that can happen. Sometimes the child cries or

develops fever or starts vomiting or convulsing and you should come to the hospital immediately."

Health Assessment

Participants were asked about the health assessment that was performed before discharge to ensure that the mother and neonate were ready for discharge. The narratives were categorized into maternal health assessment and neonatal health assessment.

Maternal health assessment.

A few mothers reported that they were asked whether they were bleeding excessively or not. A small proportion reported that the abdomen and perineum were examined, their blood pressure was recorded, and their eyes were examined. The amount of bleeding was checked before they were discharged. One mother reported, "I was checked blood pressure, the abdomen and eyes were examined to detect any problem." On the other hand, the majority of mothers reported that they had not been examined in preparation for discharge.

Neonatal health assessment.

The majority of participants reported that they were asked if the baby was breast-feeding, passing urine, and stools. Most participants also pointed out that their neonates were checked if the umbilicus was bleeding or not. A few narrated that their neonates were weighed, eyes checked for jaundice, and measured body length before discharge. The results also revealed that some neonates were not examined. One mother explained: "The baby was examined and checked on the umbilicus. I was asked if the baby was passing stools and urine and I said yes."

Treatment

A small proportion of participants reported that they were given Panadol to take home and vitamin A before discharge. A few mothers indicated that their neonates were given an immunization before discharge. The majority of participants were able to identify the type of immunization their neonates had received. Mothers reported that their neonates had been given Bacillus Calmette Guerin (BCG) and Polio vaccines. A few could not identify the type of vaccine their babies had received.

Mothers' Views on Early Hospital Discharge

Mothers in this study spent seven to twenty-three hours in the hospital before discharge. On average, mothers were spending thirteen hours after childbirth before discharge. The narratives of their views on early hospital discharge were categorized into satisfaction, dissatisfaction, and suggestions to improve the practice of early hospital discharge.

Satisfaction with Early Hospital Discharge

The majority of mothers indicated that they were satisfied with early hospital discharge following childbirth. Participants gave a number of reasons for satisfaction with early hospital discharge.

Education and counselling.

The majority reported that they were confident to go home because of the advice they received from the nurses during discharge. Mothers reported that they were given adequate information which could assist them to prevent diseases at home. One participant narrated: "I was satisfied with the early discharge because they gave me important information which can assist me at home and if I cannot follow that advice, I

can find myself in problems. I feel I had adequate information."

Maternal and neonatal health status.

Participants indicated that they were satisfied with early hospital discharge because they had no health problems. Participants reported that they were eating and walking without problems and they felt they were fit to go home. One participant explained: "I was confident to go home because I had delivered normally. I had no problems though I was feeling abdominal pains...which are normal after delivery."

Personal support.

The majority of participants narrated they were satisfied with early hospital discharge because of the presence of family members and peers at home who were doing everything for them and they had adequate time to rest. One mother narrated, "I was supported by my mother in the hospital and I was confident to go home because I was going home with her."

Hospital conditions.

A few participants stated that they were confident to go home because the hospital environment was not conducive to their comfort. Mothers stated that the toilets and bathrooms were dirty and it was difficult to take a bath. As a result mothers felt that it was better to go home and use their bathrooms. Additionally, mothers stated that there was no water at the hospital and it was difficult to take a bath and wash sanitary pads. Therefore, they felt that it was better to go home early. One mother narrated:

> I feel it is good to be discharged early because one can acquire infections at the hospital...especially from the bathrooms, because they are very dirty. Some women throw perineal pads in the bathrooms and it is easy to acquire infections. Sometimes

we do not put on shoes. It is better to be at home because the bathroom is clean. A few participants were confident to go home because the ward was over-crowded and a large proportion of mothers were sleeping on the floor with their babies.

Financial implications.

A few participants mentioned that early hospital discharge was economical because it reduced the cost. They reported that family members made fewer trips to the hospital and the hospital bill was manageable. One participant explained: **"**I was happy to be discharged early because if you stay longer, you give problems to your family members... They keep on moving up and down to visit you and it is expensive."

Rest.

Resting was also cited as an advantage of early hospital discharge. A few mothers reported that they had preferred to go home early so that they can rest. One participant stated: **"**The advantage is that one can rest at home...in the hospital there are so many people and they make noise."

Dissatisfaction with Early Hospital Discharge

Despite some mother's expressions of satisfaction with early hospital discharge, others expressed dissatisfaction. Reasons for dissatisfaction included:

Maternal and neonatal health status.

The majority of mothers explained that they had been discharged when they were not feeling well. A few indicated that they developed a complication immediately when they reached home and it was difficult to go back to the hospital. However, they had to report back to the hospital the following day. One mother narrated:

I was not confident to go home...I wasn't feeling well!... We were just discharged

because the ward was full... and they wanted other patients to find space...I had no strength to walk… I just went home because I was told to go home.

Financial implications.

A few reported that they were dissatisfied with early hospital discharge because of transport money and the long distance to the hospital. Mothers indicated that, early discharge is not good for mothers who come from far away from the hospital because they cannot manage to walk immediately after delivery if they have no transport money. Mothers stated that when a person is discharged before gaining strength and one cannot manage to walk. Therefore, one has to find money to hire a taxi or board a minibus.

Health care delivery system.

A few questioned the criterion that midwives use when discharging mothers. Mothers expressed concern that they had been discharged before thorough assessment was done. As a result there was a sense of despair because they did not know what would happen at home after they were discharged. One mother, who experienced severe abdominal pains and had no guardian, said:

> It is not good to be discharged early because a person is still weak...It is not good to discharge someone who delivered yesterday or during the night...How do you know the mother is well or not? If someone delivers today, she should spend a day in the hospital, and be discharge the following day.

Furthermore, a few mothers were dissatisfied with health services when they were told to go back to the clinic the following day after discharge. Mothers reported that after being discharged on Sunday or Saturday they were told to return on Monday for

immunization.

Rest.

A few reported that mothers needed to be discharged when they have gained strength following childbirth. Mothers reported that they needed to rest before being discharged because they would fail to perform self care at home.

Suggestions to Improve the Practice of Early Hospital Discharge

Participants were asked to give their suggestions to improve the practice of early hospital discharge following childbirth. Suggestions included: length of hospital stay, follow-up through home visits and telephone calls, and self-report to the hospital when complications arise.

Length of hospital stay.

Mothers were asked to indicate the length of hospital stay that they would prefer. The majority of them stated that their choice would depend on the health status of both the mother and the neonate. They said that if they are feeling well they will choose to go home early, if not they will stay longer. Most of the participants indicated that they would choose to be discharged the following day after delivery or after two to three days later. Reasons for their choice included need for adequate time to rest and to give nurses adequate time to make a thorough assessment before discharge. A few stated that nurses needed adequate time to assess, identify problems and give appropriate treatment. One mother explained, "I feel it is better to stay at the hospital longer because when you are sick, the nurses can monitor your progress and give you treatment, while at home there is no one to give you treatment...you just sleep."

Home visits.

The majority of participants mentioned that midwives must be following them up in their homes. Mothers explained that some people fail to visit the hospital when they experience a problem because of lack of money or because their husbands do not support them. One mother explained:

> I feel health workers should be following-up mothers in their homes to check whether they are doing well or not. We give them addresses, phone numbers and location. Sometimes the husbands may not escort their wives to the hospital or refuse to give them transport money. The nurses can assist such people at home.

Mothers suggested that they should be visited on the third day following discharge. However, a few remarked that it is not possible for nurses to follow-up mothers in their homes because there are few nurses in the hospitals. Lack of transport was also mentioned as a barrier for nurses to follow up mothers.

Telephone calls.

A few participants pointed out that there are so many cell phones these days, Therefore mothers should be calling midwives to update them on their health status. One mother explained, "These days there are phones, the hospital should keep the numbers of their clients... (Pause, looked down, laughed)... The patient should call the hospital telling the nurses their problems."

Self report.

A few of the participants mentioned that mothers should report back to the hospital a day after discharge for routine check-up or when they experience any health problem. Mothers commented that nurses at the hospital could not know the well-

being of mothers at home. On the other hand, a few commented that mothers are discharged when they are still weak and they may not manage to go back to the hospital within two to three days after discharge.

Summary of the Findings

The findings revealed that the majority of participants experienced one or more health problems such as severe abdominal pains, excessive bleeding, general body pains and weakness, breast problems, and general medical problems. The core symptom experienced by mothers that can be fatal was excessive bleeding. Furthermore, the results showed that the majority of neonates experienced health problems such as crying, which mothers associated with abdominal pains, conjunctivitis, skin infections, GIT problems, and general medical health problems. A few of the mothers reported to a health facility with their or neonate's problems while the majority did not seek any health service because they felt that the problems they experienced were normal.

The results further revealed that the majority of mothers utilized the one-week scheduled postpartum check-up visit. A few utilized outpatient, inpatient, traditional healer, and faith healers. Participants in this study received support from family members and peers during the immediate postpartum period. The majority of mothers were satisfied with early hospital discharge. A few that were dissatisfied reported that they were discharged when they were not feeling well. Lastly, mothers gave suggestions for improvement of the practice of early hospital discharge which included follow-up through home visits and telephone calls and education and counseling of mothers to report to the hospital if they experience any health problem.

CHAPTER FIVE

Discussion

Introduction

This chapter presents a discussion of the study findings, implications, limitations, recommendations for improving the practice of early hospital discharge following childbirth, and conclusions. The discussion will focus on the objectives of the study which were to: assess the health problems that mothers and neonates experience after early hospital discharge following childbirth; identify the type of the postpartum health services that mothers and neonates receive during the first week of the postpartum period; assess the type of social support mothers and neonates experience during the first week of the postpartum period after early hospital discharge; and explore mothers' views regarding early hospital discharge following childbirth. The discussion is presented under the identified major themes as follows: characteristics of participants; health problems; utilization of health services; support mothers received during the postpartum period; preparation for early hospital discharge and mothers' views on early hospital discharge.

Characteristics of Participants

Demographic data of the participants included age, marital status, educational status, employment status, ethnicity, religion, parity, and place of delivery. The participants' age ranged from 15 to 36 years. The majority were aged 21 to 25 years 12 (N=26). The significance of these findings is that the majority of participants were young and had not previously experienced the traditional practice of postpartum care. Previously mothers were spending three to seven days in hospital following

uncomplicated vaginal delivery with the traditional practice of postpartum care (Brown, et. al., 2002). Thus the young mothers may have expressed their experiences of early hospital discharge better without comparison with the traditional practice.

This study revealed that 54% of the participants had secondary education. This implies that the majority of mothers were well educated. Evidence indicates that the level of education is important because higher levels of education have a positive effect on women's use of health services (Bhatia & Clelanda, 2004). This implies that with high levels of education, mothers gain confidence and independence to demand health services. Consequently, almost all mothers in this study utilized postpartum health services, especially the one-week scheduled postpartum check-up visit.

Furthermore, the study revealed that the majority of the participants, as well as their partners, had an occupation which was a source of income in the family. Nabukera, et.al., (2006) reported that lack of transport money was a barrier to utilization of health services. Thus, employment is associated with an increase in utilization of maternal health services. This is because low income hinders opportunities to complement household financial needs and health care needs. Hence, mothers with higher income are expected to experience fewer postpartum health problems because they seek health services for labour, delivery and postpartum care early.

The study also revealed that 58% of the participants were multiparas with an average of two children per participant. Gyimah, et.al., (2005) reported that level of education is associated with a significantly reduced number of children because of starting childbearing later. Therefore, these results are not surprising because a majority of mothers in this study attained secondary education.

All participants in this study were Christians belonging to various denominations.

Religious beliefs may affect individuals' beliefs, cultural practices and utilization of postpartum health services. For instance, Gyimah, et.al., (2005) reported that the use of professional postpartum care was higher (80%) among Christian women and lower (75%) among women who identified themselves as traditionalists. This is consistent with the fact that Christians do not participate in certain traditional practices such use of traditional medicine which may put mother's or neonate's life at risk. Additionally, the sample was dominated with Tumbukas. Therefore, the experiences related to traditional practices were common to the Tumbuka tribe and they may not be generalized.

Health Problems

The results of this study indicated that the majority of mothers and neonates experienced one or more health problems during the postpartum period. Similar findings were reported in some studies on postpartum morbidity in which 84% of participants confirmed that they had suffered at least one health problem following early hospital discharge (Fikree, et. al., 2004; Vallely, et.al., 2005). In this study, these problems were grouped into sub-themes of expected maternal postpartum health problems, unexpected maternal postpartum health problems, expected neonatal postpartum health problems (normal infant behaviour), and unexpected neonatal health problems (unusual infant behaviour).

Expected Postpartum Maternal Health Problems

The study revealed that the majority of mothers experienced expected health problems during the immediate postpartum period such as abdominal pains, backache, perineal pain, pelvic and leg pain, and general body weakness. These findings are in

accordance with results from other studies which reveal that mothers may experience pain in various parts of the body such as perineum (45%), back (54.5%) and head (23%) which may remain high over the first year of the postpartum period (Cheng, et al., 2006). Gözüm and Kiliç, (2005), in a study on health problems related to early hospital discharge, also found that fatigue in women staying one night in hospital was higher than in women who stayed two nights or more in the hospital. These findings confirm that mothers experience various health problems during immediate postpartum period. Interestingly, none of the mothers in this study sought postpartum health services with these problems. However, pain or general body weakness is a barrier to mothers and it hinders timely response to meet self-care demands and the demands of the neonate. For instance, a few mothers reported that they were failing to wash their clothes or nappies unless they had taken Panadol. This shows that such health problems remain hidden problems to the mother. The significance of these findings is that mothers need to be advised to seek health services though such problems are considered normal in order to alleviate the symptoms and to promote quick recovery.

Unexpected Maternal Postpartum Health Problems

The core symptom directly related to labour and delivery that mothers experienced during the first week of the postpartum period was excessive vaginal bleeding. The majority of the participants explained that they bled excessively within the first two to four days of the postpartum period. Mothers further reported that they started experiencing abnormal vaginal discharge and lower abdominal pains during the second week of the postpartum period. This was an indication that mothers developed puerperal infections later in the postpartum period. These findings are in accordance with results from other studies which reveal that the most common complaints of

postpartum period were heavy vaginal bleeding (22%) and puerperal sepsis (34.8%) (Vallely, et. al., 2005; Gözüm & Kiliç, 2005). These problems would have been prevented or identified and treated in hospital if mothers were not discharged early from the hospital.

The study further revealed that mothers were concerned with reduced vaginal bleeding (four days) during the postpartum period. Mothers felt that they experienced reduced vaginal bleeding because of the effects of family planning methods. However, Jaramillo (2006) pointed out that postpartum bleeding should be part of the reality of childbirth for approximately four to seven days. This implies that mothers in this study lacked knowledge of the normal period for bleeding after delivery as well as of mechanisms of action of family planning methods. As a result mothers were associating normal experiences during the postpartum period with the effects of family planning methods. The significance of these findings is that, mothers need education and counseling on normal physiological changes during the postpartum period as well as mechanism of family planning methods.

The majority of mothers reported that they experienced severe abdominal pains. Mothers felt that severe abdominal pains could be due to retained products of conception or effects of labour as the uterus is returning to its non-pregnant state. Cheng, et. al., (2006); and Lagros, et. al., (2003) also made the same observations that abdominal pains alone, abdominal pains in combination with backache, and backache alone were major obstetric health problem reported by a majority of mothers in the postpartum period. The authors suggested that mothers may experience severe abdominal pains due to breast-feeding and high parity because the uterus needs to work hard to get back to its non-pregnant state. Coincidentally, mothers in this study

were all breast-feeding and the majority were multiparas. Therefore, mothers may have experienced severe abdominal pains due to breast-feeding and normal physiology of involution. However, there is need to educate and counsel mothers adequately so that they should be able to differentiate normal experiences from abnormal ones.

A few participants reported that they experienced breast problems such as breast engorgement and nipple sores. These results are similar to those reported by Gözüm and Kiliç (2005) in which 14% of mothers reported having experienced breast problems, which included sore nipple, cracked nipple, breast engorgement, and mastitis during the first week of the postpartum period. Fraser and Cooper (2009) state that between the third and fourth days after delivery breasts begin to fill with milk and this can cause breast discomfort and swelling. The authors further state that during the first days of breast-feeding nipples become tender or sore and the soreness usually goes away once breast-feeding becomes more established. However, most sore nipples that persist are the result of not attaching the baby to the breast correctly (MOH, Access, WHO, 2008). Therefore, breast problems in this study could be direct effects of early hospital discharge because midwives have limited time for teaching and counselling mothers on good positioning and attachment of baby to breast. These findings support the idea that preparation for early hospital discharge should start during antenatal period so that mothers should be acquainted with postpartum activities before giving birth (Carroli & Duarte, 2003).This will improve their skill in breast-feeding, consequently preventing breast problems.

The study further revealed that a few of the participants experienced general medical problems such as herpes zoster, malaria, cough and fever. Vallely, et. al., (2005) reported that one-fifth of the hospital admissions during the immediate

postpartum period were non-obstetric health problems such as malaria, pneumonia, and pulmonary tuberculosis. These findings suggest the importance of thorough assessment of postpartum mothers to even identify mothers' health problems which may not be purely related to childbirth, thereby improving and maintaining maternal health.

Expected Neonatal Health Problems

Expected neonatal health problems included normal infant behaviours such as crying. Mothers associated crying with abdominal pains. The majority of the participants reported crying as a major health problem experienced by their neonates. This shows that mothers were not able to differentiate normal crying behaviours from those that may indicate serious health problems. For example, UNICEF, (2008) reported that crying, vomiting, making noise while sleeping, and wriggling in newborn are normal behaviours. The significance of these findings is that mothers need more education and counselling on infant health problems so that they should be able to differentiate normal infant behaviours from those that may suggest serious health problems. This information will help them to seek health services early.

Unexpected Neonatal health problems

Unexpected neonatal health problems encompass all typical neonatal infections and other general health problems that neonates experienced during the first week of the postpartum period. Neonatal infections that the majority of neonates experienced included conjunctivitis, body sores (septic spots), oral thrush, and breast abscess. Participants in this study also reported that their neonates experienced other general health problems such as vomiting, fever, abdominal distension, cough, sneezing, and

passing bloody stools. However, these symptoms may also indicate neonatal infection as outlined in the literature (Fraser & Cooper, 2009). Similar findings are reported by Nasreen, et. al., (2006); and Raven, et. al., (2007) in which they note that more than 70% of neonates develop complications such as fever (39%), convulsions (5%), common cold (43%), jaundice (4%), diarrhoea (6%), and problems with the umbilical cord (4%). Lawn and Kerber (2007) also state that 38% of neonates in Sub-Sahara Africa die of infections during the same first week of the postpartum period. The findings in this study therefore, support the fact that neonatal infections are very common during the first week of the postpartum period. The significance of these findings is that mothers may not be able or know when to seek professional help following early hospital discharge. For this reason, there is need for thorough assessment of neonates before discharge and follow-up care within the first week of the postpartum period. Education and counselling of mothers on danger signs in neonates is also vital for early detection and treatment of any infections. Consequently, neonatal morbidity and mortality will be reduced.

Knowledge of Causes of Maternal and Neonatal Health Problems

The study revealed that few mothers had knowledge of causes of maternal postpartum health problems such as abdominal pains, backache, perineal pain, pelvic and leg pain, and severe bleeding. Mothers mentioned retained products of conception, effects of childbirth as causes of abdominal pains, backache, perineal pain, pelvic and leg pain, and vaginal bleeding. Fikree, et. al., (2004) had similar findings that the majority of women had knowledge of causes postpartum problems such as that a piece of the placenta left behind can cause excessive vaginal bleeding. These findings signify that mothers will be able to seek health services early when they are aware of

the aetiology of their health problems.

On the other hand, the study revealed that the majority of mothers identified traditional beliefs and myths as the underlying rationale for developing maternal and neonatal health problems during the postpartum period. Beliefs such as the presence of the umbilical cord on the baby and seclusion of the baby were a common rationale for mother's and neonate's experience of abdominal pains. Conjunctivitis and body sores in neonates were associated with eating too much salt, while worms were associated with distended abdomen in neonates. Similar results are reported by Fikree, et. al., (2004); Rice, et. al., (2006) and Nabukera, et. al., (2006) who found that mothers related health problems to washing clothes and utensils. The significance of these findings is that these beliefs and myths may affect mother's perception of the severity of the health problem. As a result mothers may delay seeking health services, consequently leading to high maternal and neonatal morbidity and mortality.

The study further revealed that few participants were able to identify correct causes of their neonates' health problem. Mothers mentioned heat as a cause of body rash, failure to let air out after breast-feeding as a cause of abdominal pains and vomiting. "Winding up" of intestines was mentioned as a cause of abdominal pains manifested by crying. Literature also documents that heat causes body rash and failure to let air out after breast-feeding are associated with crying of the neonate (Fraser & Cooper, 2009). The significance of these findings is that mothers may be able to seek appropriate health services if they have knowledge of the etiology of health problems. However, irrespective of knowledge of causes of health problems, health-seeking behavior was low in this study. Valdez, et. al., (2001); and Milligan, et. al., (2000) also report that mothers' practices on baby care such as breast-feeding and cord care did

not change despite having knowledge. This signifies that mothers need more education and counseling on consequences of postpartum health problems to change their behavior.

Consultation

The study revealed that the majority of participants who or their neonates experienced health problems consulted other persons about the problems before seeking a health care provider. Categories of persons they consulted included their mothers, husbands, mothers- in-law, neighbours, sisters, and health professionals. The consulted people gave mothers information on possible causes of the health problems, type of health services to attend, and home remedies to be used. A number of studies have reported the same findings that mothers initially sought advice from family members before consulting health care providers (Parvin, et. al., 2004; Cheng, et. al., 2006; Lagros, et. al., 2003). The significance of these findings is that mothers depend on significant others to seek health services. As a result they may be advised to follow harmful practices that can put their life and that of the neonate in danger.

The study further revealed that a few participants that had sought health services were motivated by the seriousness of the health problem. Similar results have been reported by Fikree, et. al., (2004) and Cheng, et. al., (2006). They found that mothers reported to the hospital when they experienced fever and chills because these were considered fatal conditions, while backache was considered normal experience during the postpartum period. Thus the success of the postpartum health outcome depends on individual's interpretation of the health problem and action to be taken. Therefore, mothers also need to be given appropriate knowledge on the physiology of potential postpartum health problems so that they can make the right decisions for their own

health care and that of the neonate, consequently leading to improved maternal and neonatal health.

Treatment

The study revealed that the majority of mothers who reported health problems in this study took action to alleviate the health problem. A few specifically attended the hospital for a health problem, while the majority used home remedies. Hot compresses (massaging), coca-cola, chombe tea leaves, Panadol, and Brufen were the commonly used treatments for abdominal pains, backache, pelvic, and leg pains. The Panadol and Brufen was either bought from nearby groceries or received at the hospital on the day of discharge or during one-week postpartum check-up visit. A few reported that they were holding abdominal muscles with *chitenje* (a cloth) to relieve abdominal pains. Similar results have been documented by Rice, et. al., (1999); Lagros, et. al., (2003) and Parvin, et. al., (2004). Lagros, et. al., (2003) reported that two-thirds of mothers who developed complications during postpartum period took pain killers sought from village drug sellers and hospital, 15% took hot compresses, 12% used African medicine, 9 % sought advice from relatives, 31% used home remedies, and 29% sought professional health worker's advice. The significance of these findings is that mothers may delay in seeking appropriate treatment, consequently increasing the incidences of reporting to the hospital when the mother or the neonate is in critical condition, consequently leading to high maternal morbidity and mortality.

The study further revealed that the majority of participants used home remedies for treatment of abdominal pains in neonates such as Gripe Water and Phillips of Magnesium. These remedies have a sedative effect (44% alcohol in Gripe Water as a preservative) which implies that the neonates will sleep and stop crying. The

significance of these findings is that neonates may not breast-feed adequately, as a result milk production will be reduced (MOH, Access, and WHO, 2008). Consequently, mothers will introduce other foods early. Milligan, et. al., (2000), in a study on breast-feeding duration, found that only 15% of mothers exclusively breast-fed their babies, while 15% and 20% introduced other foods at one and two months respectively. However, early introduction of other foods predisposes the infant to infections such as diarrhoea and malnutrition.

With regard to neonates' crying due to abdominal pains mothers believed that the problem would stop once the cord falls off. As a result mothers did not give any medication to the baby. In coincidence with the normal physiological adaptation of the neonate to extra uterine life, the frequency of crying reduced around the same period that the cord fell off (around one week) (Fraser & Cooper, 2009), thus strengthening their belief that abdominal pains cease when the cord falls off. However, mothers need to be educated so that they should be able to differentiate normal infant behaviours from abnormal ones, as these beliefs may delay seeking health services when the neonate is sick.

The study further revealed that a few mothers were applying milk or blowing into the eyes while chewing salt when babies were experiencing eye infection. These practices were based on their traditional beliefs which were passed on by elders. Carroli and Duarte (2003) also point out that early discharge can be detrimental if mothers have inadequate knowledge on health promotion-practices during the postpartum period. This is because relatives may teach mothers harmful practices, consequently putting the neonate's life at risk as these practices delay utilization of health services and also predispose neonates to infections.

Decision Making to Seek Health Services

The study revealed that the majority of participants who sought postpartum health services made the decision to visit the health facility through discussion with own mothers, mothers-in-law, and their husbands, or their husbands made the decision. A few of the participants reported that they made their own decision to seek health care but they consult their husbands before visiting the clinic. Similar results by a number of researchers have reported that women's power in decision making regarding reproductive health issues is extremely limited and women are dependent on their husbands and other older household members for decisions to seek health services (Fikree, et. al., 2004; WHO/UNICEF, 2009). Therefore, the community needs to be empowered with the maternal and neonatal health issues so that they should motivate mothers to use hospital health services. Initiatives such as *agogo (*grandmother), *mai mwana* (mother), and community-based MNH initiatives which aim at community based interventions to reduce maternal and neonatal morbidity and mortality should be encouraged (USAID, 2007).

Utilization of Postpartum Health Services

The study revealed that the majority of the participants utilized health services such as OPD, in-patient care, scheduled one-week postpartum check-up visit, traditional healers, and faith healers during the first week of the postpartum period. Similar results were reported by Hamilton, et al., (2002) and Vallely, et al., (2005) that mothers utilized acute care centres and others were re-admitted to the hospital during the immediate postpartum period.

Out-patient Health Services

The study revealed that OPD services were utilized immediately after discharge due to excessive bleeding and severe abdominal pains. However, the duration between recognition of health problems and the time decision was made to seek health care was much longer than what is expected. The common reason for the delay to seek health care was that mothers felt that the problem would resolve on its own. Similar results have been reported in a number of studies on postpartum care (Fikree, et. al., 2004; Lagro, et. al., 2003; Valley, et. al., 2005). These authors report that the period between onset of health problems and seeking hospital health care was much shorter for fever than excessive vaginal bleeding. These findings support the fact that mothers perceive vaginal bleeding and severe abdominal pains as normal experiences during the postpartum period. This signifies that failure to recognize a health problem is not the major reason why mothers delay to seek health care, rather the delay is related to individual perception of the seriousness of the health problem. Therefore, there is need for intensive education and counselling on postpartum health care to mothers and their families so that they can be motivated to seek health services early.

The study revealed that the majority of participants utilized outpatient health services with their neonates. Mothers sought health services with neonates who suffered from conjunctivitis, body sores (septic spots), vomiting, and passing bloody stools. Reasons for seeking health services were that mothers wanted to get treatment or an explanation of the cause of the problem. This shows that the health-seeking behaviour for mothers with regard to neonatal health problems in this study was high as compared to maternal health problems. The significance of these findings is that neonatal morbidity and mortality ratios may be reduced early if mothers have adequate

knowledge of consequences of neonatal health problems as compared to maternal morbidity and mortality ratios. Therefore, there is need to intensify education and counselling on the need to seek health services for maternal postpartum health problems.

In-Patient Health Services

The study revealed that the majority of participants did not utilize in-patient health services during the first week of the postpartum period for health problems directly related to labour and delivery. These findings are reassuring since high rates of re-admission due to obstetric complications might be expected following early hospital discharge after childbirth. For instance, 45% of maternal deaths occur within 24 hours after childbirth and over 65% occur during the first week of postpartum period (Fort, et. al., 2006). Interestingly, in the present study, in-patient services were only utilized for general medical problems such as herpes zoster. Similar results are reported by Vallely, et.al., (2005). The authors point out that non-obstetric postpartum morbidity including malaria and pneumonia constituted 14.5% of all admissions during the immediate postpartum period. Additionally, the majority of maternal deaths occurred due to non-obstetric health problems such as pneumonia, cryptococcal meningitis, and encephalitis. This finding suggests the usefulness of thorough assessment of mothers to identify both obstetric and non obstetric health problems for immediate treatment in the postpartum period.

The study revealed that only a few neonates required in-patient health services for management of other medical problems such as breast abscess during the first week of postpartum period. These results are encouraging since early hospital discharge is mostly associated with high neonatal morbidity requiring admission. For instance,

Hall, et. al., (2000) found that a reduction in hospital stay after delivery from 4.5 to 2.7 days without community follow-up is associated with increased re-admission to hospital, especially for hyperbilirubinemia and dehydration, after which at least two infant deaths occurred during the study. Therefore, prompt management of mothers during labour, delivery, and postpartum period should be encouraged to prevent neonatal infections and birth injuries which may result in re-admission.

One-Week Scheduled Postpartum Check-up Visit

The study revealed that nearly all participants attended the one-week postpartum check-up visit. This is contrary to results of other studies that indicated that utilization rate of postpartum health services for one-week scheduled postpartum check-up visit was very low (MDHS, 2005; Nasreen, et. al., 2006). MDHS (2005) indicates that postpartum health service utilization within the first seven days after delivery was very low (3.3%) in Mzimba District where Mzuzu City is located. Nasreen, et. al., (2006) also points out that mothers do not usually report for scheduled postpartum check-up visits unless they have faced difficulties. However, Bhtia and Clelanda (2004) comment that utilization rates of postpartum check-ups are positively and significantly associated with urban residence, educational status, place of delivery (private or public institutions), and problems that mothers experienced during delivery. Thus, it can be concluded that there was high rate of utilization of postpartum health services because the study was conducted in the city, where mothers had easy access to health services, the majority of the participants were educated, and had a source of income. Therefore, these findings may not be generalised in rural areas.

On the other hand, the study revealed that despite attending scheduled one-week postpartum check-up examinations, the majority of mothers did not present their health

problems to the midwives at the hospital. Mothers reported that they attended the one-week scheduled postpartum check-up visit only because they wanted their babies to be assessed on the umbilicus. Parvin, et. al., (2004) also found that mothers wouldn't disclose their health problem to health professionals as health professionals did not take it seriously. The authors further reported that mothers felt that health visitor's role during postpartum home follow-up visits was to check the physical well-being of the baby and, if need be, the mother. These results show that mothers do not see the importance of postpartum care for themselves. This is partly because most problems during the postpartum period are taken as normal (Lagros, et. al., 2003). Additionally, reproductive health problems are considered sensitive and mothers may not easily disclose them. The significance of these findings, therefore, is that mothers may keep the problem to themselves and present it to the hospital when major complications have developed. Consequently, this could result in high mortality rates or permanent disability. Therefore, midwives should convey clear messages on the importance of postpartum care. This will assist mothers to appreciate the importance of seeking postpartum care for both maternal and neonatal assessments.

Traditional healers and faith healers

The study revealed that the mothers did not utilize other health services such as traditional healers and TBAs for their maternal health problems. These results are contrary to findings by Fikree, et. al., (2004). They reported that mothers initially consulted traditional healers before visiting a hospital. These differences could be because the study was carried out in a city, where the majority had easy access to hospital services. For example, a study on utilization of postnatal care among rural women in Nepal, in Cambodia, by Dharkal, et. al., (2007) indicates that an increase in

distance between residence and health facility, lack of transport, and lack of good roads were commonly thought to decrease the utilization of postpartum health services during the first week of the postpartum period. These findings therefore imply that, mothers in urban areas may have lesser chances of developing life threatening complications due to harmful practices or improper treatment from traditional healers.

On the other hand, the results showed that a few participants utilized traditional healers and faith healers for neonatal health problems after being disappointed with hospital health services. Mothers reported that their neonates were discharged from the hospital before full recovery and the nurses could not identify the neonate's problem. Similar findings were reported in some studies on utilization of postpartum services (Fikree, et. al., 2004; Lomoro, et. al., 2002; Nabukera, et. al., 2006). These authors observed that poor quality care was reflected in the fact that many mothers avoided health facilities and sought health professional's care last. Mother's perception of quality of services included competence of health workers; attitude of health workers; availability of equipment and supplies; essential drugs; availability of health providers; and reputation of health care providers. This implies that persistent distrust for health professionals may strengthen mothers' desire to stay home or choose other health services or to follow practices that may be harmful to neonates.

Satisfaction with Postpartum Health Services

The study revealed that the majority of the participants were satisfied with the postpartum health care they received during the first week of the postpartum period. Similar results have been reported by Lomoro, et. al., (2002). They found that mothers were satisfied with postpartum health services because their babies' weight were checked, which assured them of the baby's health and well-being. On the other hand,

the study revealed that a few mothers were dissatisfied with the care they received. A few participants reported that the midwives did not give them any treatment or advice concerning the problems they experienced. Others reported that there were no drugs at the hospital, as a result they were told to buy drugs from the pharmacy. Similar results have also been reported by a number of researchers on postpartum care. These studies mention the attitude of midwives and lack of drugs in the hospitals as a cause of dissatisfaction with postpartum health services (Lomoro, et. al., 2002; Rice, et. al., 1999; Nabukera et. al., 2004; Cheng, et. al., 2006).

The results of the present study further indicated that a few participants were dissatisfied because they were sent back without receiving the services they sought while others were not examined when they reported to the clinic. Parvin, et. al., (2004) also report that mothers felt that their problems were not taken seriously by health workers because they were not examined properly. The significance of these findings is that misdiagnosis and unclear communication from health workers regarding health problems may discourage mothers from seeking hospital services.

Failure to Seek Health Services

The study revealed that the majority of the participants did not utilize health services during the postpartum period despite experiencing severe health problems or their neonates experiencing problems. Reasons for not using health services included the belief that the problem was normal, myths associated with causes of health problems, and advice from friends and family members to use other remedies. The significance of these findings is that mothers may not have knowledge on the relationship between their complaints and serious complications that may develop such as anemia, puerperal and neonatal sepsis. These findings are contrary to MDHS (2005)

report which indicated that mothers failed to report for postpartum health services due to lack of knowledge (16%), long distance to the clinic (60%), cost of treatment (62%) and transport (55%). Reasons for these differences could be because the present study was conducted in the urban area where health facilities are close and the majority of the participants were educated and had a source of income. However, these findings therefore, signify that there is need to explore more on factors that influence utilization of postpartum health services. This will help to have an in-depth understanding of the reason for failure to utilize the health services and come up with strategies to reach all postpartum mothers.

Social Support

Support Provided

The study revealed that the majority of the participants received support from direct family members such as husband, mother, mothers-in-law, and peers (neighbours and friends). Nearly all mothers in this study reported that they were assisted with cooking because their tradition does not allow them to use fire for one month after childbirth. Similar results have been reported by Raven, et. al., (2007); Nasreen, et.al., (2006); Cheng, et.al., (2006); Thi, et.al., (2002) who found that new mothers are not allowed to do housework during the first month after delivery because it is assumed that they are weak, and hard work could lead to low back pain and prolapsed uterus in the future. With the practice of early hospital discharge, this practice needs to be encouraged so that mothers should have time to rest and regain their strength.

The study also revealed that despite having other people looking after them at home, the majority of mothers were responsible for baby care, washing their own clothes, and the nappies. No reasons were given for this practice, but some mothers

stated that they would want to gain strength. Additionally, a few mothers performed all household tasks themselves, despite strong cultural beliefs that new mothers need rest after childbirth. Lack of support at home is contrary to popular belief about the nature of extended families in Malawi. These results correlate with the findings of Parvin, et.al., (2004); Chen, et.al., (2007); Thi, et.al., (2004); Raven, et.al., (2007); and Nasreen, et.al., (2007), who reported that the majority of mothers resumed the roles of a wife and mother quite early following hospital discharge. These findings could be the effects of urbanization where mothers are staying away from extended family members. The significance of these findings is that mothers resume household chores early and may not have time to rest during the postpartum period. Therefore, there is need for midwives to intensify education and counselling on birth preparedness and early postpartum hospital discharge during prenatal care so the mothers and the family should identify a care taker in advance. Additionally, mothers and their families need to be informed of the consequences of strain during early postpartum period, such as excessive bleeding and uterine prolapse (Fraser & Cooper, 2009). This will help them to appreciate the need for postpartum mothers to rest during the early postpartum period.

The majority of participants in this study reported that they received physical and psychological support from their husbands. Other studies also have revealed that early hospital discharge improves bonding, and the partner becomes more involved in neonatal care (Brown, et, al., 2002; Persson & Dykes, 2002). The significance of these findings is that with increased urbanization, the majority of men are aware of the need to assist their wives with household tasks during the postpartum period. This is because the majority are staying away from extended family members who were

traditionally responsible for providing physical support to the mother. Therefore, there is need to give education and counselling to men on postpartum health care so that they can participate fully in caring for postpartum mothers following early hospital discharge.

On the other hand, the study revealed that a few mothers lacked social support from their family members and they relied on peers (neighbours and friends). Khadduri, et. al., (2008), in a study on household knowledge and practices of newborn and maternal health in Haripur district, Pakistan, also found that traditional birth attendants (TBAs), friends, work colleagues, and support groups give emotional support, wash clothes, cook, and help with other household chores during the immediate postpartum period. This shows that the society is aware of the need for new mothers to have adequate rest to promote full recovery from the trauma of childbirth.

Traditional Practices during Postpartum Period

The study revealed that the majority of the mothers were not cooking during the first week of the postpartum period because they were considered unclean and that use of fire would cause men to have swollen legs. Unlike the findings in this study Raven, et. al., (2007) and Thi, et. al., (2002) report that mothers are not allowed to work because housework requires them to be in contact with either water or wind, which would then enter their body and cause arthritis and chronic aches. These practices are not harmful either to the mother or the neonate, and they should be encouraged. The significance of these findings is that mothers will have adequate time for resting.

However, a few of the study participants pointed out that they do not see the significance of these practices because they have seen that nothing happens to men whose wives use fire immediately after giving birth. Thus fear of blame from family

members and the wider community when problems arise heavily influenced mothers' adoption of traditional practices. For instance, Raven, et. al., (2007) if older people experienced health problems which they related to their behaviour during the first month of the postpartum period, they will not allow their daughters or daughters-in-law to experience similar health problems. On the other hand, if older people did not experience any problems despite not strictly following the traditional practices, they would be more lenient about the practices and allow their daughters more freedom. Therefore adherence to these traditional practices are based on the past experiences of significant others despite the shift from extended families to nuclear families. Thus neighbours and husbands were key providers of care in this study. These findings are contrary to findings of Thi, et. al., (2002). They report that with the trend to nuclear families, mothers do not fully comply with traditional practices but they re-evaluate the cultural options in the light of contemporary realities.

The study revealed that the majority of the participants were advised by elders to abstain from sexual activity for a period of six months or more. Similar results were reported by Thi, et. al., (2002); and Nasreen, et. al., (2006) who found that mothers were advised to abstain from sexual activity for a period of one year in order to avoid pregnancy and to give their bodies ample time to heal. These practices can be considered to be beneficial since they give positive effects on the health outcome of the mother and neonate in that they enable mothers who do not use contraceptives to avoid early pregnancies. However, with the advent of HIV and AIDS, mothers may risk their lives as their husbands may start having extra-marital affairs in search of sexual satisfaction. Therefore, the community needs education and counselling on normal physiological changes during the postpartum period and use of family planning

methods.

Mothers in this study reported that their babies were secluded for a period of one week till the umbilical cord fell off. These practices were shared by all participants regardless of the ethnic groups. Similar results were reported by Thi, et. al., (2002); Raven, et. al., (2007); and Nasreen, et. al., (2006) who found that postpartum mothers were kept in seclusion for a period of 40 days to protect their babies from harm such as bad weather. These practices are beneficial to the mother because mothers find time to rest and focus their attention on care of the baby. On the other hand, seclusion may prevent mothers from going back to the hospital early if they or their neonate experiences a health problem following early hospital discharge. Therefore, mothers and their families need to be given good advice on health promotion practices during the postpartum period so as to get rid of misconceptions regarding the postpartum period.

Preparation for Early Hospital Discharge

Education and Counselling

The study revealed that the majority of the study participants were given instructions on self-care and neonatal care at home following early hospital discharge. Mothers reported that they were taught about personal hygiene such as washing clothes, changing perineal pads frequently, and drying them outside the house, cleaning perineum with salty water, resting, nutrition, family planning, and scheduled postpartum check-up visits. Additionally, mothers reported that they were given information regarding neonatal care such as cord care, exclusive breast-feeding, baby positioning and attachment to the breast, maintaining neonate's personal hygiene, changing nappies frequently, weaning, immunization, and the attending under-five

clinics. Furthermore, a few of the mothers reported that they were taught about danger signs for both mother and neonate that may compel them to seek health services immediately. Nasreen, et. al., (2006) also found that mothers had knowledge on mothers' care following delivery such as providing nutritious food (90%) and maintaining cleanliness (99%). Jacobs, et. al., (2001) also report that 80% of mothers were aware of danger signs for neonates. The most commonly recognized danger signs were fever (65%), convulsions (77%), difficulties in breathing (60%), and difficulties in breast-feeding (15%) (Jacobs, et. al., 2001). The implication of these findings is that when mothers have knowledge on health promotion practices and danger signs they will be able to seek medical care early, and thus lead healthier lives. As a result, maternal and neonatal morbidity and mortality will be reduced, consequently achieving MDGs 4 and 5.

One of the most challenging finding in this study is that the majority of mothers reported that they have forgotten some information of what they were taught. Bolam, et. al., (1999) and Cheng, et. al., (2000) report similar findings that mothers failed to recall all information given to them in preparation for early hospital discharge, despite the fact that key messages related to essential care and danger signs in the postpartum period were provided. One of the reasons for failure to recall could be the fact that the majority of mothers are taught on the day of discharge, when mothers are excited about going home and do not concentrate. Failure to recall the information may have a negative impact on mothers' self-care and that of the neonate. For example, mothers may fail to recognize health problems for themselves and for the neonate, thereby delaying to seek health services.

Additionally, the majority of participants reported that they were given group health

education. For this reason mothers had difficulties to concentrate and did not have the opportunity to be appropriately counselled, or given time to reflect upon the messages. This implies that mothers go home with limited knowledge of health promotion practices. As a result mothers may fail to provide self-care and that of the neonate, consequently leading to high maternal and neonatal morbidity and mortality. To improve the situation, Mazia, et al., (2009) recommends that additional less skilled staff, other community health workers, and the media should be mobilized to reinforce the messages in the communities following early discharge from the hospital.

Health Assessment

The study revealed that essential elements of the history and physical examination were carried out before discharge. Mothers reported that they were asked whether bleeding was excessive or not. A few of the participants reported that they had their blood pressure, eyes, abdomen, and perineum assessed, and the amount of bleeding checked. However, a few reported that health assessment was not done in preparation for early hospital discharge. Lomoro, et. al., (2002) also reported that mothers received all prescribed postpartum examinations with exception of blood pressure measurement which was received by only half of the mothers. Failure to perform a thorough assessment of mothers before early hospital discharge amounts to missed opportunities to identify and treat complications early. As a result there is increased morbidity and mortality during the early postpartum period. Therefore, mothers should be assessed carefully before they leave the hospital to ensure that they are going home in good health.

Regarding neonatal health assessment, a few of the mothers reported that they were asked if the baby was passing urine, stools, and breast-feeding without difficulties. The

majority of the participants reported that the neonates were not examined thoroughly, except for the umbilicus to assess if it was bleeding or not. A few of the participants that reported that the babies were examined pointed out that babies were weighed, eyes checked for jaundice, and the body length was measured with a tape. Similar results were reported by Mazia, et. al., (2009) and Lomoro, et. al., (2002). They found that mothers commented that their babies were only weighed and given eye examination, though early postpartum period is a critical period for neonate's survival. This signifies that neonates may be discharged without having their immediate health problems addressed. As a result there could be an increased morbidity and mortality rate during the early postpartum period. Therefore, midwives should be encouraged to adequately assess the neonates before giving them early hospital discharge, since they spend the subsequent period of time at home without the supervision of a health professional.

The majority of the neonates were given immunizations before discharge such as BCG and Polio vaccines, while others mentioned vitamins instead of Polio. These findings show that mothers were not aware of the type of immunization that was given to the neonates. Nasreen, et. al., (2006) also point out that mothers knew that their babies were supposed to receive immunization, but only a few were aware of the type of immunization that their babies received, as well as number of vaccines that their babies were supposed to receive. These findings imply that midwives should use effective communication skills so that mothers should gain adequate knowledge on important aspects of maternal and neonatal care before discharge.

Mothers' Views on Early Hospital Discharge

The results of the study revealed that mothers were either satisfied or dissatisfied with the practice of early hospital discharge. The results further revealed that mothers

gave in their suggestions for the improvement of the practice of early hospital discharge.

Satisfaction with Early Hospital Discharge

The study revealed that the majority of participants were satisfied with early hospital discharge following childbirth. Mothers indicated that they were satisfied because they had normal delivery, had no health problems and they felt that they could manage on their own at home. However, other studies that have been conducted on postpartum care have revealed that postpartum period is a period of biophysical and social restoration. Fifty percent of mothers develop complications such as PPH, sepsis, and pre-eclampsia despite being health on discharge (Lawn & Kerber, 2007). Therefore, it is difficult to know which mother or neonate will develop a complication during the postpartum period, although they experienced a normal vaginal delivery. Thus the midwives should advise mothers on danger signs during the postpartum period for both the mother and neonate, regardless of mode of delivery.

The majority of participants in this study reported that they were satisfied with early hospital discharge because they received adequate information which assisted them at home. Similar results were reported by Lomoro, et. al., (2002) who found that mothers were given adequate information on recognition of danger signs and health promotion practices during the postpartum period. The importance of these findings is that mothers are capable of providing self-care as long as they have adequate information on health promotion practices. Therefore, midwives have a duty to properly educate and counsel mothers on postpartum care activities, so that the mothers should be able to provide self-care, identify problems early, and seek health services.

The study further revealed that mothers were satisfied to go home because they had

family support. Mothers reported that, they were supported by their mothers in the hospital and they were going home with them. As such they were confident to go home. Other studies conducted in developed countries also reveal that mothers felt that early hospital discharge is important if it was accompanied by nursing visits and 24-hour telephone line and a home worker (Dana & Wambachi, 2000; Persson & Dykes, 2002). These findings demonstrate the need for the presence of support persons' during the postpartum period. It should be emphasised that mothers expressed satisfaction with the care regardless of their relationship to the primary care giver. This is contrary to the results of Montigny, et. al., (2006). Their results indicate that grandmothers, especially from the maternal side, were more supportive in giving advice and information regarding postpartum period. These differences could be because the majority of participants in the present study practice the partrilineal system, in which both parents have interest in the health of the mother and the neonate.

The study also revealed that the majority of the mothers reported that early hospital discharge helps to create space, since the hospitals are overcrowded and some mothers sleep on the floor with their babies. These findings are in line with the reasons for establishing the practice of early hospital discharge following childbirth. The practice of early hospital discharge originated in the Western world (USA & UK) as a response to shortage of hospital beds (Lůanaigh & Carlson, 2005; Wickham, 2005). However, the implication of this finding is that mothers may accept early discharge even when they are not feeling well, just to create space. Additionally, midwives may discharge mothers even if they are not ready for discharge in order to create space. Consequently, re-admission rates of mothers and neonates will increase.

Poor hospital environment was identified as another reason why mothers were

satisfied to go home early. Mothers reported that bathrooms and toilets were very dirty and sometimes there was no water. As a result mothers were finding problems to maintain personal hygiene. Thus mothers felt that the benefit of early hospital discharge is that they avoid acquiring infections from the hospital. Similar results have been reported by Brown, et. al., (2002). The authors found that the disadvantage of long hospital stay was the risk for prolonged exposure to nosocomial infection. Therefore, health professionals should take precautions to ensure that hospitals are clean and safe for the clients. This in turn will improve the utilization rate of maternal and neonatal health services, including labour and delivery.

The other reason why mothers were satisfied with early hospital discharge was that they felt that early hospital discharge was cheap. Mothers felt that early hospital discharge reduces hospital bills and family members made fewer trips to the hospital. Malkin, et.al., (2003) and Dan and Wambachi (2003) also report that hospitalization charges including labour charges were statistically less in early discharge group as compared to long hospital stays. The significance of these findings is that with the practice of early hospital discharge, even mothers with low income may utilize health services for labour and delivery. Thus, early hospital discharge may increase skilled attendance at birth and consequently reduce maternal and neonatal mortality.

Desire to get adequate rest was another reason why mothers were satisfied with early hospital discharge. Participants reported that they would rather be discharged early so that they get adequate rest at home. Brown, et. al., (2002), in a study on early postpartum discharge for health mothers and neonates, also found that mothers were satisfied with early hospital discharge because they felt more relaxed in their homes than at the hospital.

Dissatisfaction with Early Hospital Discharge

This study has also revealed that a few participants were dissatisfied with the practice of early hospital discharge because they felt that they were discharged when they were not feeling well. Mothers reported that they were feeling pain and discomfort from birth processes as well as pain from perineal stitches. As such mothers felt confused when discharged within 24 hours. Parvin, et. al., (2004) also found that mothers expected the hospital to be the place to recuperate after childbirth and where they could be taken care of by staff. Klingner, et al., (1999) and Rice, et. al., (1999) also report in their studies that mothers were dissatisfied to go home early because they valued rest and sleep, which they may not get at home due to other children and household responsibilities. The significance of these findings is that mothers seemed to have feelings that the home environment could not offer the same comfort they felt they needed for their postpartum recovery such as rest, availability of drugs to relieve pain and attention from professionals. Therefore, mothers should be educated and counselled on advantages of early hospital discharge such as early ambulation which promotes recovery.

A few of the participants associated early hospital discharge with risks of developing complications immediately after they reach home. Mothers narrated that, there was a possibility of developing a complication that required a health professional's attention. WHO and World Bank (1997) as cited by Lawn and Kerber (2007) also point out that 50% to 70% of mothers and neonates respectively develop life-threatening complications such as PPH, sepsis, pre-eclampsia and neonatal sepsis, birth asphyxia, birth trauma, tetanus, diarrhoea, pneumonia , and jaundice during the immediate postpartum period. A delay even by few hours in starting appropriate care

for mothers and neonates facing such complications can be fatal or result in long-term disability. Therefore, mothers and neonates need to be adequately assessed before early hospital discharge and followed-up to monitor how they are adjusting, both physically and psychologically, following childbirth.

The study also revealed that mothers were dissatisfied with early hospital discharge because of their inability to cover emergency costs such as hiring a vehicle when complications arise. Mothers reported that it was difficult to go back to the hospital due to financial constraints and long distances. Nabukera, et. al., (2006) had similar results in a study on use of postpartum services. They found that lack of transport money, particularly mothers living far from a health facility, was a barrier to utilization of postpartum services. This implies that despite the services being theoretically free, indirect costs such as financing travel to and from the clinic may be considerable barriers to utilize the services. As a result mothers may suffer in silence or use traditional medicine which may also put them at risk of getting other infections. Therefore, when implementing early hospital discharge, health professionals should ensure that mothers are adequately assessed to rule out any possible immediate complication that may require mothers to report back to the hospital.

The study revealed that few mothers had a sense of despair when they were discharged early from the hospital. They stated that they did not know what would happen at home after discharge. On the other hand, Persson and Dykes (2002) in a study on parent's experiences with early hospital discharge found that mothers felt early hospital discharge enabled them to feel a sense of self control and autonomy to take care of themselves and the neonate. These differences may be due to the fact that in developed countries early hospital discharge is accompanied by follow-up care by

community midwives hence mothers feel confident to go home. Mothers in this study could have this sense of despair due to lack of family and health professional's support during this period.

This study also revealed that mothers who were discharged during the weekend were dissatisfied with the health care delivery system because they were told to return to the hospital for immunization a day after discharge, as immunizations were not given during the weekend. Furthermore, the participants were advised to report to the clinic for scheduled one-week postpartum check-up visit within the same week. Lomoro, et. al., (2004) also reported that mothers were not satisfied with midwife's follow-up care during the first week of the postpartum period because of timing of the visits. These findings imply that health care programmes were interrupting mother's ample time for resting. These results, therefore, signify that there is need for integration of services to reduce the number of hospital visits, consequently reinforcing health-seeking behaviors and promoting rest.

This study further revealed that a few of the participants were dissatisfied because they did not understand what was being taught due to noise from guardians and personal discomfort from pain. Participants narrated that they were not concentrating on the teaching because they had severe abdominal pains. These findings concur with Olds, et. al., (2004). These authors state that the first 24 hours after childbirth are the taking-in phase and are not conducive to learning. This implies that health education given during the immediate postpartum period may not be effective because the mother is still recovering from trauma of childbirth. Thus despite being provided with adequate information during preparation for discharge, mothers may still consult significant others for advice when a complication arises. Consequently mothers may

practice harmful practices which may endanger their lives and that of the neonate.

A few of the participants reported that they were not satisfied with early hospital discharge because they were not examined or given health education before being discharged. A significant implication of early hospital discharge therefore is that mothers and neonates are discharged before many important post-birth health needs are addressed. For this reason, women with little knowledge, experience or support, are at greater risk of being influenced by friends and relatives to perform harmful practices such as insertion of herbs into the vagina to reduce the size of the vagina instead of performing exercises (Fikree, et. al., 2004; Lawn & Kerber, 2007). However, in this study, both primparas and multiparas consulted more than one person for their health problems before consulting health professionals. This finding indicates the need for community midwives to follow-up these mothers in their homes to assess how they are adjusting during the postpartum period.

Suggestions to Improve the Practice of Early Hospital Discharge

When asked for their views regarding early hospital discharge, the majority of the participants indicated that their choice about length of hospital stay will depend on their health status. The participants stated that if they are feeling well they would choose to go home immediately and if not they would choose to stay longer. A few of the participants indicated that they would choose to stay two to three days so that they should get adequate rest and that midwives should have adequate time to make thorough assessment before discharge. These findings show that mothers feel they were discharged before they were ready for discharge. Rice, et. al., (1999) also found that a quiet environment and attention from health professionals who could give comfort and confidence were reasons why mothers would like to stay longer at the

hospital. Thus Parvin, et. al., (2004) point out that the problem with the maternity care system is that sometimes it uses the "one size fits all" policy. In this policy all mothers are discharged early with little consideration about individual needs. Therefore, allowing mothers to have a choice on length of hospital stay may have a positive influence on mothers' perception of the postpartum period.

The results further revealed that the majority of the participants in this study suggested that midwives must be following-up mothers in their homes to improve the practice of early discharge. They suggested that mothers should be followed-up on the third day following delivery. These findings are congruent with WHO recommendations for early hospital discharge, which stipulates that mothers should be followed-up at 2-3 days and 6-7 days during the immediate postpartum period (Lawn & Kerber, 2007). A few remarked that it may not be possible for midwives to follow-up mothers in their homes because midwives are few and they may not have transport. However, Cheng, et. al., (2006) argue that although initial cost of home visits is higher than hospital-based care, home visits by midwives may be cost effective. This is because midwives may have an opportunity to provide comprehensive care to the mother. Comprehensive care could result in a great impact on mothers' mental and physical status which may lead to improved maternal and neonatal health status.

Limitations of the Study

The sample for this study was drawn from a small geographical area of Malawi. Therefore the results can only be generalised in Mzuzu City only.

The majority were educated and had a source of income. Hence, it may be difficult to generalize the results to the general population. Additionally, the majority of participants were above 20 years of age and multiparas and so the results may not be

generalised to the adolescent and primiparas population.

The study explored mother's experiences during the first week of the postpartum period following uncomplicated vaginal delivery following early hospital discharge. This may affect have an effect on the findings as some life threatening health problems may not be revealed. However, it was the author's intention to describe the experiences of mothers who are considered health on discharge.

Recommendations

The findings in this study have identified gaps in the immediate postpartum care with regard to early postpartum early hospital discharge. Therefore, the researcher finds it necessary to make recommendations to those concerned with maternal and neonatal health issues for implementation of safe and effective early postpartum hospital discharge following childbirth.

The study revealed that maternal and neonatal infections are common during the first week of the postpartum period. Therefore, monitoring the recovery period after childbirth is as essential as any other component of maternity care in order to reduce maternal and neonatal morbidity and mortality ratios. The researcher therefore recommends that reproductive health policy makers in Malawi should consider including a policy on home follow-up visits within the first week of the postpartum period. This will provide optimal time of learning for the mothers, and also an ideal time for midwives to assess for postpartum health problems, since no one can predict which mother or neonate will experience a complication following early hospital discharge. Studies that have been conducted in Bangladesh, Pakistan, and India have revealed that home postpartum follow-up visits reduced newborn mortality by 30 to 61%. This is because the home visits improved coverage of education and counselling

on health promotion practices and identification of health problems and seek appropriate health professionals care early (WHO/ UNICEF, 2009; Kumar, et. al., 2008). Therefore, this strategy may also be effective in Malawi to deal with postpartum health problems thereby improving maternal and neonatal health. However, the problem of shortage of skilled health personnel may not allow skilled health professionals to make home visits. Studies that were conducted in developing countries revealed that the use of non-skilled health workers to provide home based maternal and neonatal care after appropriate training was effective (WHO/UNICEF, 2009). Therefore, the researcher recommends that non-skilled health workers such as village health volunteers and health surveillance assistants (HSA) be empowered with knowledge on maternal and neonatal health issues so that they can visit postpartum mothers in their homes. These health workers can educate and observe how mothers are carrying out health promotion practices such as cord care and breast-feeding and refer those mothers with health problems to the hospital early. Consequently, the mother's knowledge, skills, and attitudes gained during discharge will be reinforced.

The researcher further recommends that midwives should consider conducting studies on the prevalence and types of maternal and neonatal health problems following early hospital discharge and factors that contribute to the development of postpartum health problems in the home. Evidence shows that it is difficult to define, interpret, and measure postpartum maternal and neonatal morbidity using hospital data because of the small proportion of mothers that seek medical care when they develop a complication (Vallely, et. al., 2005). Therefore, these studies will shade more light regarding postpartum health problems and help health policy makers to put evidence based strategies in place to reduce maternal and neonatal morbidity and mortality in

Malawi.

The study revealed that thorough health assessment was not done on majority of mothers and neonates during preparation for early hospital discharge and when mothers attended the scheduled one-week postpartum check-up health services. The researcher therefore recommends that, midwives should perform a thorough health assessment on both the mother and the neonate to ensure that they are healthy before discharge. This will reduce the chances of discharging mothers or neonates that indicate the likelihood of developing complications. Studies conducted in Karachi, in Pakistan and Zambia revealed that mothers do not spontaneously or voluntarily reveal their health problems (Lagros, et. al., 2003; Firkree, et. al., 2004). Thus, thorough assessment may result in identification of many health problems which mothers could not reveal such as foul smelling discharge, infected tears and episiotomies, and haemorrhoids.

Lack of knowledge on expected and unexpected maternal and neonatal health problems and their causes was another gap that was identified in this study. Therefore midwives should not assume that mothers know the relationship between certain complaints and serious postpartum conditions that need medical attention. It is therefore recommended that midwives should educate mothers on normal physiological changes during the postpartum period and that certain signs and symptoms indicate serious conditions regardless of age, cultural background, educational and economic status, religious affiliation, and parity. This information will help them to differentiate normal experiences from abnormal ones. Studies that were conducted in Guatemala on reproductive health revealed that 84% of mothers reported to the health facility after providing them with knowledge on danger signs for both the

mother and the neonate (Jacobs, et. al., 2007).

The study also revealed that some mothers were provided with inadequate information and health assessment was incomplete during the preparation of the mother and neonate for early hospital discharge. Hospital management should consider updating midwives knowledge and skills through in-service education in order to improve the quality of postpartum care services. Mazia, et. al., (2009) in Swaziland reported that the competence of the health workers related to postpartum examination, education, and care of babies and mothers improved after training health workers on provision of early postpartum care.

Additionally, the study revealed that majority of mothers could not recall all the information that was provided in preparation for early hospital discharge. This was probably due to the fact that mothers are given too much information during a short period of time while they are still exhausted with the effects labour and delivery. It is therefore recommended that midwives should teach mothers together with their family members including the husband so that they remind the mother if certain issues have been forgotten. Furthermore, midwives should consider developing postpartum care pamphlets containing messages on health promotion practices and danger signs for both mother and neonate and be given to mothers. This will act as a reference material as a result mother will be reminded of what they were taught before discharge from the hospital.

Furthermore, the researcher recommends that policy makers should consider designing guidelines and policies (discharge plan) for early hospital discharge following childbirth and they should be made available to midwives. This will promote uniformity of care provided to mothers and neonates before discharge. This researcher

also recommends that a research study on quality of postpartum care services should be carried out. This study may reveal the factors that hinder or promote provision of quality postpartum care. Evidence reveals that failure to perform thorough assessment of mothers may be associated with shortage of equipment and supplies as well as health personnel to perform the procedures (UNICEF, 2008). As a result health workers aim at finishing the job than providing quality care that will sustain life.

The study also revealed that majority of mothers depended on decisions made by significant others to seek health care services. The implication of these findings is that mothers may be influenced by relatives to follow harmful practices that may put their lives and that of the neonate in danger. It should be recommended therefore, that, midwives should consider organising mass campaign for maternal and neonatal health issues in order to empower communities. The campaign could be through community visits; school visits; use of mass media such as radios, television, and newspapers; mobile phone messages; and distribution of pamphlets on postpartum care to community members. This will help mothers and significant others to take appropriate action when mothers or neonates develop a complication. Pilot studies that have been conducted in Mchinji (mai mwana project), Malawi revealed that mothers in the community were able to identify priority maternal health problems such as PPH, sepsis, pre-eclampsia, anaemia after empowering the community with maternal and neonatal health messages (Rosato, et. al., 2006). Furthermore, the midwives should consider conducting a study on factors that influence the utilization of the postpartum health services in Malawi. This will help to have an in-depth understanding of the reason for failure to utilize the health services and come up with strategies to reach all postpartum mothers.

Another gap that was identified in this study was lack of social support at home as a result mothers resumed household chores early. Therefore, there is need for midwives to intensify education and counselling on birth preparedness and early postpartum hospital discharge during prenatal care so that the mothers and their families should identify a care taker in advance. This can be achieved by incorporating education on postpartum care into prenatal; postpartum; schools at primary, secondary and tertiary level; and community health services.

Additionally, midwives should also consider involving husbands when counselling mothers on postpartum care. Husbands who are already helping their wives during the postpartum period can be the entry point to intensify male involvement campaign on maternal and neonatal health services as these can act as role models. This will allow partners to have in-depth knowledge of postpartum health care, thereby increasing participation in the care of postpartum mother and neonate. WHO (2001) also commented that special efforts should be made to emphasize men's shared responsibility and promote their active participation in parenthood.

There is need to replicate this study on a larger scale because these results are from a sample of small geographical area and they cannot be generalized. Additionally, this study was exploring mothers' experiences during the first week of the postpartum period, and thus the results reflect information available at one time of the postpartum period. Therefore, a longitudinal study of mothers throughout the postpartum period would provide more information regarding mothers' experiences during the postpartum period following early hospital discharge. Cheng, et. al., (2006) pointed out that assessments used to measure maternal health status should address complications and discomforts throughout the postpartum period. Thus longitudinal

studies would be the best to determine mothers' experiences during the postpartum period.

Conclusion

This study has added insights into health problems that mothers and neonates experience during the first week of the postpartum period; health services utilized; the support system available to mother at home following early hospital discharge; preparation of the mother before early hospital discharge; and mothers' views on early hospital discharge. The study has revealed that the majority of mothers and neonates experience health problems during the first week of the postpartum period. It was found that it is not possible to predict which mother or neonate will experience health problems after hospital delivery. It was also noted that the majority of mothers were not able to differentiate between expected and unexpected health problems during the immediate postpartum period. As such the majority of maternal and neonatal health problems that required medical attention were not evaluated. Thus the outcomes of this study have identified risks that can be associated with early hospital discharge, specifically the delay in seeking health services, high dependency on household members on decision making to seek health services, inadequate rest at home, incomplete assessment of mother and neonate and provision of inadequate education and counselling during the preparation for early hospital discharge. Therefore, mothers who are discharged from the hospital within 24 hours after childbirth and their families should be educated about potential health problems that may arise during the postpartum period, and should be encouraged to seek appropriate and timely care.

Nevertheless, the length of hospital stay is not likely to increase. These facts signify the importance of establishing standards of care for the provision of early postpartum

hospital discharge. It is the responsibility of all midwives, physicians and other health care personnel, including administrators and funding agencies, to ensure early hospital discharge after childbirth is implemented in a safe and effective manner.

REFERENCES

Bahadoran, P., Mohsen, M., and Abedi, H. (2008). Mothers experiences of postpartum period: a phenomenological study. *Iranian Journal of Nursing Midwifery Research, 13* (3), 110-115. Retrieved 01.29.2010 from http://journals.mui.ac.ir/index.php/ijnmr/article/viewfile/3030/1197.

Bhatia, J. C., and Cleland, J. (2004). Determinants of maternal care in the region of south India. *Health Transition Review, 65*, 127-142. Retrieved 01.31.2010 from http://dspace.anu.edu.au/bitstream/1885/41182/Bhati .

Bolam, A., Manandhar, D., Shrestha, P., Ellis, M. and Costello A.M., (1999). The effects of postnatal health education for mothers on infant care and family planning practices in Nepal: randomised controlled trial. *BMJ, 316,* 7134: 805- 811. Retrieved on 2.3.2009 from http://www.cochrane.org/reviews/en.

Brooten, D. Youngblut, J. M., Brown, L., Finkler, S.A., Neff, D.F., and Madigan, E. A. (2001) Randomized trial of nurse specialist home care for women with high risk pregnancies: outcome and costs. *Am J managed Care, 7* (8), 793 -803.

Brown, S., et.al. (2002). Early postnatal discharge from hospital for health mothers and term infants. *Cochrane database of systems review*. Issue article No: CD002958 DOL: 10.1002/14651858. Retrieved 03.03.2009 from http://www.cochrane.org/reviews/en.

Burns, N. and Grove, S. K. (2005). *The practice of nursing research conduct, critique and utilization (5th ed.)*. St. Louis: Elsevier.

Carroli, C., & Duarte, (2003). Early postnatal discharge from hospital for healthy mothers and Infants: RHL commentary. *The WHO Reproductive Health Library:* Geneva: WHO. Retrieved 03.04.2009 from http://www.who.int/rhl/pregnancy_childbirth/care_after_childbirth/gccom3/en/index.html.

Castro, R., Campero, L., Hernåndez, B., and Langer, A. (2000). Maternal mortality in Mexico through a qualitative approach. *Journal of Women's Health and Gender based medicine, 9* (6), 679-690. Retrieved on 10.10.2009 from http://www.liebertonline.com.

Cheng, C., Fowles, E., R., and Walker, L.O. (2006). Postpartum maternal health care in the United States: A critical review. *Journal of Perinatal Education, 15* (3), 34-42. Retrieved 06.11.2010 from http://www.nbi.nlm.nih.gov/pmc/articles/PCM1595301.

Chhay, S. (2008). *Factors influencing postpartum checkups among mothers in Cambodia*. Mahidol University. Retrieved on 09.25.2009 from http://www.grad.mahidol.ac.th/grad/.

Concise edition dictionary and thesaurus. (2006). Scotland: Geddes and Grosset.

Concise Oxford Dictionary (11th ed.). (2004). New York. Oxford University Press.

Dana, S.N., and Wambachi, K. A. (2003). Patient satisfaction with early discharge home visit program. *Journal of Obstetrics, Gynaecology and Neonatal Nursing*, *32*. Retrieved 01.31.2010 from http://www.susandanarn.com/JGONNpdf.

Declercq, E.R., Sakala, C., Corry, M. P., Applebaum, S., and Risher, P. (2002). *Listening to mothers; Report of the first national U.S survey of women's childbearing experience*. New York: Maternity Childbearing Association. Retrieved on 12.30.2010 from http://www.ncbi.nlm.nin.gov/pmc.

Dhakal, S., Chapman, G. N., Simkhada, P. P., Van Teijlingen, E.R., Stephens, J., and Raja, A. E. (2007). Utilization of postnatal care among rural women in Nepal. *Biomed Central Pregnancy and Childbirth*, *7* (1), 19. Retrieved 01.28.2010 from http://www.ncbi.nlm.nih.gov/pmc/articles/pmc20755091.

Elo, S., and Kyngäs (2007). The qualitative content analysis process. *Journal of Advanced Nursing*, *62* (1), 107-115.

Firkree, F.F., Ali, T., Durocher, J. M., and Rahbar, H.M (2004). Health service utilization for perceived postpartum morbidity among poor women living in Karachi. *Social Science and Medicine*, *59*, 681 -694. Retrieved 02.17.2010 from http://www.elsevier.com/location/socscimed.

Fraser, D. M., & Cooper, M. A. (2009). *Myles text book for midwives* (14th ed.). Edinburgh: Churchill.

Fort, A.I., Kothari, M., and Abderrahim, N. (2006). *Postpartum care: Levels and determinants in developing countries. DHS comparative report number 15.* Calverton, Maryland, Macro International. Retrieved 10.02.2010 from http://www.magweb.org/techbriefs/postp.shtml.

Government of the Republic of Malawi Ministry of Health (2004). *Handbook and guide for health providers on essential health package in Malawi*: *Understanding the EHP.* Planning Department.

Gözüm, S., and Kiliç, D. (2005). Health problems related to early discharge of Turkish women. *Midwifery*, *21* (4), 371- 378. Retrieved 01. 28.2010 from http://www.sceincedirect.nextbio.com.

Gyimah, S.O., Takyi, B. K., and Addai, I. (2005). Challenges to the reproductive health needs of African woman: On religion and maternal health utilization in Ghana. *Science and Medicine*, *62* (12), 2930-2944.

Hall, R.T., Simon, S., and Smith, M. (2000). *Readmission of breastfeeding infants in*

the first two months. Retrieved 04.10.2009 from http://www.ncbi.nlm.nih/gov/pubmed/11076327.

Huque, Z. (1999). *Safe motherhood programmes in Bangladesh in safer motherhood initiatives critical issues*. London: Blackwell science Limited. Retrieved on 5.5.2009 from http://www.popline.org/docs/1316/147660.html.

Jacobs, E., Brambila, C. and Vernon, R. (2001). *Reproductive health care in the postnatal period in Guatemala*. USAID. Retrieved 08.05.2009 from http://www.popcouncil.org/frontier/fr_finalReport/Guatamala_postnatal_Care.pdf.

Jaramillo, M.D. (2006). Bleeding: Normal or cause for concern? *Pregnancy*, Retrieved 06.16.2010 from http://pregnancy.org/article/bleeding_normal_or_cause_concern.

Khadduri, D. R., Marsh, B., Rasmussen, A., Bari, R., Nazir, B., and Darmstadt, G. L. (2008). Household knowledge and practices of newborn and maternal health in Haripur district, Pakistan. *Journal of Perinatology, 28*, 182–187. Retrieved 05.12.2009 from http://www.ncbi.nlm.nih.gov/pmc/article/PMC1595242.

Klingner, J.M. Solberg, L. I., Schumacher, S.K., Carlson, R.R., and Huss, K.L. (1999*) Effective clinical practice: how satisfied are mothers with 1- day hospital stays for routine Delivery?* November- December. Retrieved 03.01.2009 from http://www.ncbi.nlm.nih.gov/pubmed/10788022.

Kumar, V., Mohanty, S., Kumar, A., and Mijra, A. (2008). Saksham study group. Effects of community based behaviour change management on neonatal mortality in Shivgarh, Utta Pradesh, India: A cluster-randomised controlled trial. *Lancet, 372* (9644), 1151-1162. Retrieved on 30.12.2010 from http://www.ncbi.nlm.nih.gov/pubmed.

Lagros, M., Liche, A., Mumba, T., Ntebeka, R., and Roosmalen, J., (2003). Postpartum health among Rural Zambian women. *African Journal of Reproductive Health, 7* (3), 41-48. Retrieved 01.29.2010 from http://www.ncbi.nlm.gov/pubmed/15055145.

Lawn, J. E., Cousens, S., and Zupan, J. (2005). 4-million neonatal deaths: when? Where? Why? *Lancet, 365*, 891-900. Retrieved on 12.29.2010 from http://www.who.int/child_adolescent_health_documents.

Lawn, J. E. and Kerber, K. (2007). *Opportunities for Africa`s newborn. Practical data, policy and programmatic support for newborn in Africa, Partnership for maternal, newborn and child health.* Cape Town: Retrieved 07.15.2009 from http://www.who.int/pmnch/medical/publications.

LoBiondo- Wood, G. and Haber, J. (2005). *Nursing research: methods and critical appraisal for evidence based practice (6th ed.).* St. Louis: Mosby, Inc.

Lock, M., Joel, P and Ray, J.G. (1999). Higher neonatal morbidity after routine early hospital discharge. Are we sending newborns home too early? *Canadian Medical Association Journal, 161* (3), 249. Retrieved on 01.31. 2010 from http://www.cmaj.cal.cgi/content.

Lomoro, O. A., Ehiri, J.E., Qian, X., and Tang, S.L. (2002). Mothers perspectives on the quality of postpartum care in central Shanghai, China. *International Journal for quality in health care, 14* (5), 393. Retrieved 01.29.2010 from http://www.ajph.org/cgl/content/abstract/8815/777.

Lůanaigh, P. O´., and Carlson, C. (2005). *Midwifery and Public Health: future directions and new opportunities.* Edinburgh: Churchill Livingstone.

Lungu, K., Kamfosa, V. M., Hussein, J., and Ashwood-Smith, H. (2001). Are Bicycles Ambulances and Community transport plans effective in strengthening Obstetric Referral System in Southern Malawi. *Malawi Medical Journal, 13* (2), 16-17.

Madlon-Kay, D. J., Defor, T. A., and Egerter, S. (2003). Newborn length of stay, health care utilization and the effects of Minnesota legislation. *Arch paediatric Adolescent Medicine, 153,* 579-583. Retrieved on 12.30.2010 from http://archpedi.am-assn.org/cgi/content.

Malkin, J. D., Keeler, E., Broder, M. S., and Garber, S. (2003). Postpartum length of stay and newborn health: A cost effectiveness analysis. *Paediatrics, 111* (4), 316-322. Retrieved on 12.31.2010 from http://www.paediatrics.aappublications.org/cgi/content.

Mazia, G., Narayanan, I., Warren, C., Mahdi, M., Chibuye, P., Williго, A., Mabuza, P., Shongwe, R. and Hainsworth, M. (2009). Integrating quality postnatal care into PMTCT in Swaziland. *Global Public Health, 4* (3), 253 – 270.Retrieved 12.23.2009 from http://www.informaworld.com/smpp/title.

McGovern, P., Dowd, B., Gjerdingen, D., Gross, C. R., Kenney, S., Ukestad,L., McCaffrey, D., and Lundberg, U. (2006). Postpartum health of employed mothers 5 weeks after childbirth. *Annals of Family Medicine, 4* (2), 159-167.

Miligan, R.A., Push, L.C., Bronner, Y.L., Spatz, D.L. and Brown, L. P. (2000). Breastfeeding duration among low income women. *Journal of midwifery and Women`s Health, 45* (3), 246-252. Retrieved 01.31.2010 from http://whalecomwww.sciencedirect.com/whalecomO/science .

Ministry of Health (RHU), Access, and WHO. (2008). *Pre- service initiative: Basic Emergency Maternal and Neonatal care: lesson plans.* Lilongwe: Government of Malawi.

Montigny, F., Lacharite, C., and Amyot, E., (2006). The transition to fatherhood: the role of formal and informal support structures during the postpartum period. *Texto context Enferm Florianǒpolis oùt-Dee, 15* (4), 601-609. Retrieved on 02.12.2010

from http://www.scielo.br/pdf/tce/v15n4/v15n .

Mzuzu Central Hospital. (2009). *Maternity annual Report 2008/2009 financial year.* Unpublished report.

Nasreen, H., Imam, N., Akter, R., and Ahmed, S.M. (2006). *Safe motherhood promotion project in Narsingdi District- baseline survey. 2006*. Tong; BRAC. Retrieved 08.05.2009 from http://www.bracresearch.org/publications/jica_baseline.pdf.

Nabukera, S.K., Witte, K., Muchunguzi, C., Bajunirwa, F., Batwala, V. K., Mulogo, E. M., Farr, C., Barry, S., and Salihu, H.M. (2006). Use of postpartum health services in Rural Uganda: attitudes, knowledge, and barriers. *Journal of Community Health*, *31* (2), 84-93 Retrieved 02.18.2010 from http://www.springerlink,com/content .

National Statistical Office and UNICEF. (2008). *Malawi multiple indicator cluster survey 2006 final report: monitoring the situation of children and women*. Zomba: National Statistical Office.

National Statistical Office. (2005). *Malawi demographic health survey 2004.* Zomba: National Statistical Office.

National Statistical Office. (2008). *2008 population and housing census: preliminary Report.* Zomba: National Statistical Office. Retrieved 08.20.2009 from http://www.nso.malawi.net/data_on_line/demography/census_2008/MWCensus08_report.pdf.

Olds, S.B., London, M.L., Ladewig, P.A., and Davidson, S. V. (2004). *Maternal –newborn Nursing and women's health care (7th ed.).*Upper Saddle River: Pearson Education Ltd.

Parvin, A., Jones, C.E., and Hull, S. (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladesh women living in Tower Halmlets. *Oxford Journals Family Practice*, *21* (2), 254-260

Persson, E.K., and Dykes, A. (2002). Parents' experiences of early discharge from hospital after birth in Sweden. *Midwifery*, *18* (1), 53-60. Retrieved 06.25.2009 from http://hinari.gw.who.int/whalecomwww.sciencedirect.com .

Polit, D.F. and Beck, C.T. (2010). *Essentials of nursing research: methods, appraisal and utilization (6th ed.).* Philadelphia: Lippincott Williams and Wilkins.

Radmacher, P., Massey, C., and Adamkin, D. (2002). Hidden morbidity with successful early discharge. *Journal of Perinatology*, *22* (1), 15-20. Retrieved 09.25.2009 from Http://www.nature.com/jp/journal/v22/n1/full/7210586a.html.

Raven J.H., Chen, Q., Tolhurst, R.J., and Garner, P. (2007). Traditional beliefs and

practices in the postpartum period in Fujian Province, China: a qualitative study. *BMC Pregnancy Childbirth, 7* (8), . Doi: 10.1186/1471-2393-7-8. (Pubmed). Retrieved on 05.17.2010 from http://creativecommons.org/licenses/by/2.0).

Redshaw, M. (2007). Knowing what we know: process, impact and outcomes: the case of early discharge. *MCH Journal, 21* (6), 22-25. Retrieved 04.05.2009 from http://www.latrobe.edu.au/.../early%20discharge%20knowing%20what%.

Republic of Malawi, MOH. (2005). *Emergency obstetric care services in Malawi: Report of Nationwide Assessment.* Lilongwe: UNFPA, WHO and UNICEF.

Rice, L.P., Naksook, C., and Watson, L. (1999). The experiences of postpartum hospital stay and returning home among Thai mothers in Australia. *Midwifery, 15* (1), 47-57. Retrieved 11.08.2009 from http://www.sciencedirect.com/science.

Salaria, M., Gupta, P., and Bishit, H. J. (2001). Early discharge of normal term neonates continued dilemma. *Indian Paediatrics, 38*, 1374-1381.Retrieved 03.04.2009 from http://asmedasantioquia.org/eventos/altemprana-neonatal.doc.

Sines, E., Syed, U., Wall, S. and Warley, H. (2007). *Postnatal care: A critical opportunity to save mothers and newborns policy perspectives on newborn health.* Washington DC: Save the Children. Retrieved on 05/08/09 from http://www.savethechildren.org.

Speziale, H. J .S. and Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing humanistic imperative (4th ed.).* Philadelphia: Lippincott Williams and Wilkins.

Rosato, M., Mwansambo, C.W., Kazembe, P.N., Phiri, T., Soko, Q.S., Lewycka, S., B. E. Kunyenge, Vergnano, S., Osrin, D., Newell, M. L., AM., and Costello, A.M. (2006). Women's groups' perceptions of maternal health issues in rural Malawi. *Lancet*, 368, 1180-1188.

Schroeder, M.A. (2006). Is immediate postpartum period crucial to the mother-child relationship? *Journal of obstetrics, Gynaecology and Neonatal nursing, 6* (3), 37-40. Retrieved 01. 28.2010 from http://www3.interscience.wiley.com/journal/119632842.

Sector Wide Approach (SWAp). (2008). *The status of reproductive health within the sector wide approach context Malawi: Toward universal access to reproductive health*. Mailman School of Public Health. Columbia University.

Thi, L. M., Pasandarntorn, W., and Rauyajin, R. (2002). Traditional postpartum practices among Vietnamese mothers in Anthi District, Hung Yen Province. *Health Policy and Planning, 20* (5), 319-327 Retrieved 01.02.2010 from http://heapol.oxfordjournals.org/cgi/content/full/20/5/319.

Torkan, B., Parsay, S. Lamieian, M., Kazemnezhad, A., and Montazeri, A. (2007).

Comparative analysis of life quality in mothers after caesarean section and normal vaginal delivery. *Iranian Journal of Nursing and Midwifery Research, 12* (1), 1-5 Retrieved 01.30.10 from http://www.journals.mui.ac.ir/index.php/ijnmr/article/viewfile/1868/734.

UNICEF. (2008). *Countdown to 2015: Tracking progress in maternal newborn and child survival, the 2008 report*. New York: UNICEF. Retrieved on 12.29.2010 from http://www.countdown2015.mnch.org/ .

USAID and Save the Children (2007). *Malawi Newborn Health Design Workshop* Capital hotel Lilongwe. USAID. http://www.pdf.usaid.gov/ .

Valdez, J., Seims, L. Mijoni, B. Leburg, C., and Johnson, B. (2001). *Umoyo Network Malawi: Baseline survey results for six organisations*. Washington DC: NGOs Networks for health project Retrieved 08.11.2009 from http://www.chain.net.

Valley, L., Ahmed, Y., and Murry, L.S. (2005). Postpartum maternal morbidity requiring hospital admission in Lusaka, Zambia- descriptive study. *BMC pregnancy and childbirth, 5* (1), 12-18 Retrieved 08.05.2009 from http://www.biomedcentral.com.

Wickham, S. (2005). *Midwifery: best practice volume 3.* Edinburgh: Elsevier Limited.

Winterburn, S. and Fraser, R. (2000). Does the duration of postnatal stay influence breast-feeding rates at one month in women giving birth for the first time? A randomized control trial. *Journal of Advanced Nursing*, 32 (5), 1152–1157.

WHO/UNICEF. (2009). *Home visits for the newborn child: strategy to improve survival.* Retrieved on 12.31.2010 from http://www.whqlibdoc.who.int/hq/2009/WHO_FCH_CAH_ .

WHO. (2001). *Health for all in the twenty-first century*. Retrieved on 12.05.2009 from http://www.who.int.archives/infa/policy.htm .

World Health Organization. (2004). *Beyond the numbers: Reviewing maternal deaths and complications to make pregnancy safer*. Retrieved 07.3. 2009 from www.who.int/reproductive-health/publications/btrytext.pdf .

Yonkers, K.A., Ramin, S.M., and Rush, A. J. (2001). Persistence of postpartum depression in an inner city maternal health clinic system. *American Journal of Psychiatry*. Retrieved 01.31.2010 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1894757.

APPENDIX A: INTERVIEW GUIDE

INTERVIEW GUIDE

ID CODE:_____
NAME OF INTERVIEWER:_____
DATE: _____

PART ONE: DEMOGRAPHIC DATA (tick)

1. How old are you?
   a) 15 -20 [ ]
   b) 21- 25 [ ]
   c) 26 – 30 [ ]
   d) 31 – 35 [ ]
   e) 36 and above [ ]
2. What is your marital status?
   a) Single [ ]
   b) Married [ ]
   c) Separated [ ]
   d) Divorced [ ]
   e) Widowed [ ]
3. What is your tribe?
   a) Yao [ ]
   b) Chewa [ ]
   c) Tumbuka [ ]
   d) Tonga [ ]
   e) Other specify_____
4. What is your religion?
   a) C. C. A. P. [ ]
   b) Roman Catholic [ ]
   c) Anglican [ ]
   d) SDA [ ]
   e) Other specify_____
5. How far did you go with your education?
   a) None [ ]
   b) Primary education [ ]
   c) Secondary education [ ]
   d) Tertiary [ ]
   e) Other specify_____
6. How far did your partner go with education?
   f) None [ ]
   g) Primary education [ ]
   h) Secondary education [ ]
   i) Tertiary [ ]
   j) Other specify_____
7. What is your main occupation?
   a) Teacher [ ]
   b) Nurse [ ]

c) Engineer [ ]
d) Business [ ]
e) Other specify_____

8. What is the occupation of your partner?
   a) Teacher [ ]
   b) Nurse [ ]
   c) Engineer [ ]
   d) Business [ ]
   e) Other specify_____
9. How many children do you have?
   a) 1 – 2 [ ]
   b) 3 – 4 [ ]
   c) 5 – 6 [ ]
   d) 6 and above [ ]
10. Where did you give birth to this child?
   a) Mzuzu central hospital [ ]
   b) Mzuzu Health Center [ ]
   c) St. Johns Hospital [ ]
11. What is the date of birth for this child?_____
12. What was the mode of delivery for this child?
   a) Normal vaginal delivery [ ]
   b) Breech delivery [ ]
   c) Vacuum extraction [ ]

PART TWO: MOTHERS` EXPERIENCES DURING THE FIRST WEEK OF POSTPARTUM PERIOD

1. Tell me any health problems that you or your baby experienced during first week of the postpartum period at home.

   Probes:
   a. What physical or psychological health problems did you experience?
   b. What problems did the baby experience?
   c. What do you think is the cause of the problem?
   d. Whom did you consult when you identified the problem?
   e. Why did you consult that person?
   f. How were you assisted by this person you?
   g. What remedies did you take to alleviate the problem?
   h. Where did you seek help or treatment for yourself or your baby during first week of the postpartum period?
   i. In your family who made the decision to seek health care?

2. Please, tell me postpartum health services that were available to you during the first week of postpartum period.

   Probes:

a) Did you visit any health facility during the first week of postpartum period?
b) Which health facility did you visit?
c) What influenced your choice of a health facility?
d) What type of health services did you need at this facility?
e) Who informed you of these health services?
f) Did you receive the services that you needed?
g) Were you satisfied with the services?
h) If no, why were you not satisfied with the services?

3. Tell me the family support that you received during the first week of postpartum period.

Probes:

a) Which family members provided support to you during the first week of postpartum period?
b) What kind of support did they provide?
c) How long was the support provided?
d) If no support was provided, how did you cope with the care of yourself, the baby and the family?
e) Were there any challenges that you experienced regarding caring for yourself and the baby during the first week of postpartum period?
f) Were you satisfied with the support that you received?
g) If no, why were you not satisfied?

4. Please tell me your views regarding postpartum early hospital discharge.

Probes:

a) How confident were you to look after yourself and the neonate at home?
b) How were you prepared for early hospital discharge?
c) What information did the midwives teach you about self-care at home in order to promote your health and that of the neonate in preparation for early discharge?
d) Explain to me if you think you had adequate information to identify or protect yourself and the neonate from developing health problems?
e) What assessments were done on you and your baby by midwives in preparation for discharge from the hospital?
f) Were you satisfied with the preparation?
g) If no why you were not satisfied with the preparation?
h) What are the advantages of early hospital discharge?
i) What are the disadvantages of early hospital discharge?
j) Given a chance to choose the period of hospital stay, how long would you have chosen to stay and why?
k) What do you think should be done to ensure continued midwifery care during the first week of postpartum period following early discharge after childbirth?

APPENDIX B: MAFUNSO

MAFUNSO

NAMBALA YA KALATA YA MAFUNSO:_____
DZINA LA OFUNSA MAFUNSO_____
TSIKU_____

GAWO LOYAMBA (CHONGANI YANKHO LOMWE MUKUGWIRIZANA NALO)

Poyamba ndikufunsani ma funso okhudzana ndi inu.

1. Kodi Muli ndi zaka zingati?
    a) 15 -20 [ ]
    b) 21- 25 [ ]
    c) 26 – 30 [ ]
    d) 31 – 35 [ ]
    e) 36 and above
2. Kodi muli pa banja?_____
3. Kodi ndinu wa mtundu wanji?
    a) Yao [ ]
    b) Chewa [ ]
    c) Tumbuka [ ]
    d) Tonga [ ]
    e) Zina_____
4. Kodi mumapemphera mpingo wanji?
    a) C. C. A. P. [ ]
    b) Katolika [ ]
    c) Angilikani [ ]
    d) SDA [ ]
    e) Zina_____
5. Kodi maphunziro anu munalekezera pati?
    a) Pulayimale [ ]
    b) Sekondale [ ]
    c) Zina_____
6. Kodi amuna anu maphunziro awo analekezera pati?
    d) Pulayimale [ ]
    e) Sekondale [ ]
    f) Zina_____
7. Kodi mumagwira ntchito yanji?
    a) Mphunzitsi [ ]
    b) Namwino [ ]
    c) Injiniya [ ]
    d) Bisinezi [ ]
    e) Zina_____
8. Nanga a muna anu amagwira ntchito yanji?

a) Mphunzitsi [ ]
b) Namwino [ ]
c) Injiniya [ ]
d) Bisinezi [ ]
e) Zina_____

9. Kodi muli ndi ana angati?
   a) 1 – 2 [ ]
   b) 3 – 4 [ ]
   c) 5 – 6 [ ]
   d) Kuposera 6 [ ]
10. Kodi mwana ameneyu anabadwa liti?_____
11. Nanga mwana ameneyu anabadwira kuti?
   a) Mzuzu central hospital [ ]
   b) Mzuzu Health Centre [ ]
   c) St. Johns Hospital [ ]
12. Kodi mwana ameneyu anabadwa bwanji?
   a) Ndinachila bwinobwino [ ]
   b) Fula [ ]
   c) Kuchita kukoka [ ]

GAWO LA CHIWIRI- MAFUNSO OKHUDZANA NDI UMOYO WANU SABATA LOYAMBA MUTATULUKA KU CHIPATALA

1. Tafotokozani matenda amene inuyo kapena mwana anadwalapo mutatuluka muchipatala musabata yoyamba mwana atabadwa?

   Kufunsitsa:
   a) Kodi munadwalapo matenda anji inuyo mutatuluka muchipatala musabata yoyambilira mutangochila kumene?
   b) Kodi mwana anadwalapo matenda anji mutatuluka muchipatala musabata yoyambilira atangobadwa kumene?
   c) Kodi mukuona kuti chinayambitsa matenda amenewa ndi chiyani?
   d) Mutaona kuti inuyo kapena mwana sakupeza bwino munamuuza ndani?
   e) Chifukwa chiyani munawuza munthu ameneyu?
   f) Kodi munthu ameneyu anakuthandizani bwanji?
   g) Kodi munapangapo chiyani kuti inuyo kapena mwana apeze bwino?
   h) Tafokozani, komwe munakapeza chithandizo kuti inuyo kapena mwana a peze bwino.
   i) Tafokozani, pabanja panu pano amene analamula kuti matenda a inuyo kapena mwana mupite nawo kuchipatala?

2. Tafotokozani chithandizo cha za umoyo chomwe munachipeza musabata yoyamba mwana atabadwa.

   Kufunsitsa:
   a) Tafokozani komwe munakalandira chithandizo cha za umoyo

musabata yoyambirira mwana atabadwa?

b) Tafokozani amene anakudziwitsani kuti mukafune chithandizo cha za umoyo kuchokera kumalo amenewa?
c) Kodi munalandira chithandizo chotani kuchokera kwa a za umoyo?
d) Kodi munali wokhutitsidwa ndi chisamaliro chomwe munalandira kuchokera kwa a zaumoyo?
e) Ngati simunakhutitsidwe, mungafotokozepo zifukwa zake ?

3. Tafotokozani mwatsatanetsatane chisamaliro chomwe munali nacho sabata yoyamba mutatuluka kuchipatala mwana atabadwa ku chokera kwa a chibale.

Kufunsitsa:

a)Tafotokozani amene amakusamalirani musabata yoyamba mutatuluka kuchipatala mwana atabadwa
b) Anthu amenewa amakupsani chisamaliro chotani ?
c)Kodi anthu amenewa anakusamalirani nthawi yayitali bwanji ?
d) Ngati panalibe munthu amene amakupatsani chisamaliro, inuyo mumakwanitsa bwanji kudzisamalira komanso kusamala mwana pamodzi ndi banja lonse?
e)Panali zovuta zanji zomwe inuyo mumakumana nazo zokhudzana ndi chisamaliro chanu kapena cha mwana musabata imeneyi?
f) Kodi munali wokhutitsidwa ndi chisamaliro chomwe munalandiracho ?
g) Ngati simunakhutitsidwe, mungafotokozepo zifukwa zake ?

4. Tafotokozani maganizo anu pa ndondomeko yomwe wogwira ntchito ya za umuyo amatsata yotulutsa amayi muchipatal pasanathe maola 48 atabeleka mwana.

Kufunsitsa:

a) Pamene mumatuluka ku chipatala, kodi munali wokhutitsidwa kuti mutha kukadzisamalira nokha pamodzi ndi mwana kunyumba?
b) Tafotokozani zimene azamba anakuchitirani pa nthawi yomwe amakonzekera kuti akutulutseni muchipatala
c) Kodi munalandira uphungu wotani pokonzekera kutuluka muchipatala?
d) Tafokozani zimene azamba anakupimani inuyo komanso mwana pa nthawi imene amakonzekera kukutulutsani muchipatala?
e) Kodi munali wokhutitsidwa ndi uphungu womwe munalandirawo?
f) Ngati simunakhutitsidwe ndi uphungu kapena kapimidwe komwe azamba anapanga pokonzekera kuti mutuluke muchipatala, mungafotokozepo zifukwa zake?
g) Inuyo, mukuona kuti ubwino wake ndi wotani kuti amayi azituluka mwansanga muchipatala?
h) Nanga mukuwona kuti kuyipa kwake ndi kotani?
i) Mutapatsidwa mwayi osankha nthawi yoyenera kukhala muchipatala inu mutha kusankha kuti mukhale nthawi yayitali bwanji? Chifukwa chiyani mungasankhe nthawi imeneyi?
j) Inuyo mukuona kuti woyang'anira nkhani ya uchembere wa bwino achitepo chiyani pa nkhani yotulutsa amayi nsanga kuchipatala kuti umoyo wa mayi ndi mwana ukhale wa thanzi?

APPENDIX C: PARTICIPANT INFORMATION LETTER

Study Title: Early Hospital Discharge Following Childbirth: Mothers Experiences During the First Week of the Postpartum Period at Home in Mzuzu City.

My name is Mrs. Judith Chirembo and I am a student at Kamuzu College of Nursing pursuing a Masters Degree in Midwifery. The purpose of this study is to explore mother's experiences with early hospital discharge during the first week of the postpartum period. There are no immediate benefits that you will get for participating in this study but the results will generate knowledge which will be used to design reproductive health policy and guidelines on postpartum care which would result in provision of quality maternal and neonatal care.

If you take part in this study, you will be asked some questions about your experiences with early hospital discharge during the first week of the postpartum period. Data will be collected in your home. The data collected from the interview will be audio-tape recorded and hand written. The information that you will provide will be kept confidential and anonymous as your name will not be used on the recordings. Identity code numbers will be used on both interview guide and tape recordings instead. The tape recordings as well as interview guides and field notes will only be accessible to authorised persons such as the research supervisor. The documents will further be destroyed at the end of the research process.

Participation in this study is voluntary and you are free to withdraw any time. There are no risks associated with your participation in the study. However, the interviews will be taking 30 to 45 minutes which means much of your time will be consumed. The purpose and significance of the study will be explained to your husband or friends and family members, if anyone of these objects your participation in this study, you will not be interviewed to avoid family conflicts.

If you decide to take part, you will be asked to sign a consent form to ascertain that you are participating in this study after getting adequate information relating to the study. You are also free to contact the following persons if you have any queries or you feel your rights were violated.

Judith Chirembo (Mrs.): Kamuzu College of Nursing, P. O Box 415 Blantyre. Cell: 0999280621/0888624984.

Dr. E. Chirwa : Main Research Supervisor, Kamuzu College of Nursing, P. O Box 415 Blantyre. Cell: 0888940513.

Mrs R. Msolomba: Second Research Supervisor, Kamuzu College of Nursing, P. Bag 1, Lilongwe. Cell: 0999180931.

The Chairperson: College of Medicine Research and Ethical Committee, P/Bag 360, Chichiri, Blantyre 3. Telephone: 01 877245/ 291

APPENDIX D: KALATA YA NDONDOMEKO WA KAFUKUFUKU

Mutu wa Kafukufuku: Umoyo wa Amayi ndi Mwana Sabata Yoyamba Mwana Atabadwa

Dzina langa ndine Judith Chirembo. Ndine wophunzira pa sukulu ya anamwino ya Kamuzu. Panopa ndikupanga kafukufuku wofuna kudziwa za umoyo wa a mayi awo atulutsidwa kuchipatala muma ola 24 atabeleka bwinobwino. Ndiye Ndikukupemphani kuti mukhale nawo m'modzi wa anthu omwe anganenepo zaumoyo wawo pamodzi ndi mwana kuchokera panthawi yomwe adatulutsidwa muchipatala kufikira lero. Koma musanayambe kundifotokozera maganizo anu, ndafuna kuti ndikudziwitseni zolinga ndi kufunikira kwake kwa kafukufuku ameneyu.

Cholinga cha kafukufuku ameneyu ndi kufuna kumva kuchokera kwa inu momwe mumakhalira kuno kunyumba musabata yoyamba mutatulutsidwa muchipatala. Zotsatira zakafukufuku ameneyi zidzathandiza akulu akulu a unduna wa za umoyo kukonza ndondomeko za m'mene angaperekere chisamaliro kwa amayi akatuluka muchipatala atabeleka ndi cholinga chakuti amayi pamodzi mwana a khale ndi moyo wa thanzi.

Mukavomereza kutengapo mbali mukafukufuku ameneyi, mudzafunsidwa mafunso wokhudzana ndi umoyo wanu pa modzi ndi mwana kuno ku nyumba musabata yoyambirira mutatuluka mchipatala. Zonse zomwe mudzafotokoze zidzatepedwa ndipo zina zizidzalembedwa. Zonse zomwe mudzafotokoze zidzasungidwa mwa chinsinsi ndipo palibe munthu amene adzadziwe zomwe inu munanena. Dzina lanu silidzalembedwa pa kalata ya mafunso kapena kutepedwa. M'malo mwake mudzapatsidwa nambala yomwe idzalembedwe pachikalata chamafunso komanso kutepedwa ngati dzina lanu. Kuwonjezera apo, palibe munthu aliyense yemwe a dzamvere kapena kuwerenga zomwe inu mwanena popanda chilolezo. Komanso, matepi ndi mapepala omwe talembamo zomwe inu mwanenena zidzaonongedwa pomalizira pa kafukufuku ameneyi**.** Chinanso choti mudziwe ndichakuti, ndinu womasuka kutengapo mbali mukafukufu ameneyu ngati mukufuna kutero kapena kusiya panthawi iliyonse yomwe mwaganiza kutero ndipo izi sizidzasokoneza ufulu wanu wolandira chithandizo cha za umoyo kuchipatala mutsogolo muno. Muyenera kudziwa kuti ubwino wake wotengapo mbali mukafukufukuyu siwalero lomwe koma udzathandiza kukonza ntchito za umoyo wa amayi ndi mwana akatuluka muchipatala.

Muyenera kudziwa kuti kutenga nawo mbali mukafukufuku ameneyu palibe chovuta chilli chonse chomwe chingakuchitikireni pa moyo wanu. Komabe mafunso amenewa azitenga nthawi yayitali (phindi 30-45) kusonyeza kuti nthawi yanu yambiri ithera pamenepo. Kuwonjezera apo ngati mukuwona kuti mafunso ena akufuna kudziwa zomwe inu mumaziwona kuti ndizachinsinsi, muli omasuka kusiya osayankha mafunso otero. Ngati a muna anu kapena a chibale sakufuna kuti mulowe nawo mukafukufuku ameneyu, muli omasuka kusiya osalowa nawo. Ngati mwavomereza kutengapo mbali mukafukufuku ameneyu muyenera kulemba dzina lanu pa malo omwe aperekedwa pa kalata ya chilolezo kusonyeza kuti mwamvetsetsa zolinga ndi kufunika kwa Kafukufuku ameneyu ndipo mwalola kutenga nawo mbali. Mutha kufunsanso kwa anthu amene maina awo ali munsimu ngati mutafuna kutero.

Judith Chirembo (Mrs.): Kamuzu College of Nursing, P. O Box 415

Blantyre.
Cell: 0999280621/0888624984.

Dr. E. Chirwa : Main Research Supervisor, Kamuzu College of Nursing,
P. O Box 415 Blantyre.
Cell: 0888940513.

Mrs R. Msolomba: Second Research Supervisor, Kamuzu College of Nursing, P. Bag 1, Lilongwe.
Cell: 0999180931.

The Chairperson: College of Medicine Research and Ethical Committee, P/Bag 360, Chichiri, Blantyre 3.
Telephone: 01 877245/ 291.

APPENDIX E: INFORMED CONSENT FORM

Study Title: Early Hospital Discharge Following Childbirth: Mothers Experience During the First Week of the Postpartum Period at Home in Mzuzu City.

I agree to participate in the research study conducted by Mrs Judith Chirembo who is a postgraduate student of the Masters program of Kamuzu College of Nursing having understood the purpose and significance of the study. I understand that my participation in this study is voluntary and that I may withdraw at any time without consequences to my health care in future. I understand that the interviews will take 30-45 minutes in my home. I understand that all information will be confidential and that I will never be personally identified in published or unpublished materials. I understand that the documents and tape recordings will be destroyed at the end of the study. I have received the names and telephone number of the advisors so that I can ask questions and concerns about the study. My signature on this form verifies my intention to participate in this study.

Signature:_____ Date:_____

Name of Researcher:_____ Date:_____

Judith Chirembo (Mrs.):	Kamuzu College of Nursing, P. O Box 415 Blantyre. Cell: 0999280621/0888624984.
Dr. E. Chirwa:	Main Research Supervisor, Kamuzu College of Nursing, P. O Box 415, Blantyre. Cell: 0888940513.
Mrs R. Msolomba:	Second Research Supervisor, Kamuzu College of Nursing, P. Bag 1, Lilongwe. Cell: 0999180931.
The Chairperson:	College of Medicine Research and Ethical Committee, P/Bag 360, Chichiri, Blantyre 3. Telephone: 01 877245/ 291.

APPENDIX F: KALATA YACHILOLEZO

Mutu wa Kafukufuku: Umoyo wa Amayi ndi Mwana Sabata Yoyamba Mwana Atabadwa

Ine ndine wokonzeka kulowa nawo mukafukufuku yemwe a kupanga Judith Chirembo wophunzira pa sukulu ya anamwino ya Kamuzu. Ndamvetsetsa zolinga ndi kufunika kwake kwa kafukufuku ameneyu. Ndamvetsetsa kuti sindine wowumirizidwa kulowa nawo mukafukufuku ameneyu ndipo ndine wololedwa kusiya nthawi ina iriyonse yomwe ndaganiza kutero ndipo kuti izi sizidzasongoneza mwayi wanga wolandila chithandizo cha za umoyo mtsogolo muno. Ndamvetsetsa kuti ndidzafunsidwa mafunso omwe azitenga phindi 30 - 45 ndipo kuti izi zikachitikira kunyumba kwanga.

Ndamvetsetsa kuti zomwe ndidzanene mukafukufuku ameneyu sidzasungidwa mwachnsinsi ndipo dzina langa silidzatchulidwa kapena kulembedwa pena paliponse. Ndapatsidwa maina ndi nambala za lamya za a phunzitsi awo kuti ndikhale ndi mwayi wofuna kufunsa za kafukufuku ameneyu ngati nditafuna kutero.

Ndamvetsetsa kuti kulemba dzina langa pa malo amene aperekedwa pansipawa kukusonyeza kuti ndamvetsetsa cholinga cha kafukufuku ameneyu ndipo ndine wokonzeka kutenga nawo mbali.

Dzina_____ Tsiku_____

Dzina la Mwini wa Kafukufuku_____ Tsiku_____

Judith Chirembo (Mrs.): Kamuzu College of Nursing, P. O Box 415
Blantyre.
Cell: 0999280621/0888624984.

Dr. E. Chirwa: Main Research Supervisor, Kamuzu College of Nursing,
P. O Box 415, Blantyre.
Cell: 0888940513.

Mrs R. Msolomba: Second Research Supervisor, Kamuzu College of
Nursing, P. Bag 1, Lilongwe.
Cell: 0999180931.

The Chairperson: College of Medicine Research and Ethical Committee,
P/Bag 360, Chichiri, Blantyre 3.
Telephone: 01 877245/ 291.

APPENDIX G: CERTIFICATE OF APPROVAL FROM KAMUZU COLLEGE OF NURSING RESEARCH AND PUBLICATION COMMITTEE

University of Malawi
Kamuzu College of Nursing

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE OF STUDY: *Early hospital discharge following child birth: mothers experience during first week of postpartum period at home in Mzuzu City*

INVESTIGATOR(S) JUDITH KALARE CHIREMBO

REVIEWER RPC

DATE OF REVIEW: 16th October, 2009

OVERALL RECOMMENDATIONS: APPROVED WITH MINOR CORRECTIONS

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING
2009 -10- 21
DEAN OF POSTGRADUATE & RESEARCH STUDIES.
PRIVATE BAG 1, LILONGWE.

SIGNATURE:.....**DATE**21/10/09
DEAN OF POSTGRADUATE STUDIES AND RESEARCH

CC: supervisor:

DECLARATION OF INVESTIGATOR(S)
I/We fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/We guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/We will resubmit the proposal to the committee.

DATE22/10/09 **SIGNATURRE(S)**.....

APPENDIX H: LETTER OF APPROVAL FROM COLLEGE OF MEDICINE RESEARCH AND ETHICAL COMMITTEE

UNIVERSITY OF MALAWI

Principal

Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:

Your Ref.: P.11/09/845

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 877 245
01 877 291
Fax: 01 874 700
Telex: 43744

5th March 2010

Mrs Judith Kalale Chirembo
Kamuzu College of Nursing
Blantyre Campus
Blantyre 3

Dear Mrs Chirembo,

P.11/09/845 – Early hospital discharge following Child Birth: Mothers experience during First Week of Postpartum Period at Home in Mzuzu City

I write to inform you that COMREC reviewed your proposal which you resubmitted for expedited review. I am pleased to inform you that your proposal was approved on 5th March 2010 after considering that you addressed all the queries which were raised during the previous review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours Sincerely,

Approved by College of Medicine
- 5 MAR 2010
(COMREC)
Research and Ethics Committee

Prof. J. M. Mfutso Bengo
CHAIRMAN - COMREC

JMMB/ck

APPENDIX I: CLEARANCE LETTER FROM MZUZU CITY ASSEMBLY

MZUZU CITY ASSEMBLY

THE CHIEF EXECUTIVE

Telephone: Mzuzu (265) 310 177/310 446/310 319
Fax : (265) 310 475
E-mail : mzuzucity@sdnp.org.mw

Civic Office
P.O. Box 1
Mzuzu,
MALAWI.

Your Ref : .....
MCA/~~8~~31 121
Our Ref: :.....

DIRECTOR OF ADMINISTRATION
MZUZU CITY ASSEMBLY
12 MAR 2010
P.O. BOX 1, MZUZU

12th March, 2010

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

The bearer of this letter is Mrs. Judith Chilembo who has been granted permission to conduct the research study on mothers experience during first week of postpartum period at home within the city.

This permission is valid for 30 days from 15th March to 15th April 2010.

Any assistance rendered to her will be greatly appreciated.

Yours faithfully,

V.M.C. MASINA
DIRECTOR OF ADMINISTRATION AND PERSONNEL
FOR: CHIEF EXECUTIVE

CCP/mmk

CC: The Officer In charge
Mzuzu Police station
P.O. Box 16
MZUZU

ALL CORRESPONDENCE TO BE ADDRESSED TO THE CHIEF EXECUTIVE

APPENDIX J: CLEARANCE LETTER FROM MZIMBA NORTH DHO

Telephone: + 265 01 311 061
+ 265 01 310 579
All Communications should be addressed to:
DISTRICT HEALTH OFFICER

In reply please quote no.....
MINISTRY OF HEALTH AND POPULATION
MZIMBA NORTH DHO
P.O. BOX 299
MZUZU
MALAWI.
11th March 2010

Mrs Judith Chirembo,
Kamuzu College of Nursing
Blantyre Campus
P.O. Box 415,
Chichiri
BLANTYRE 3.

Cc: The Incharge, Mzuzu Health Centre

Dear Sir/Madam,

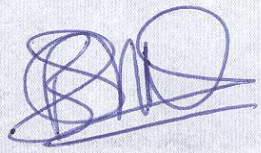
RE: PERMISSION TO VISIT OUR FACILITIES TO IDENTIFY PARTICIPANTS FOR A RESEARCH STUDY ON MOTHERS EXPERIENCE DURING THE FIRST WEEK OF POSTPARTUM PERIOD AT HOME

Reference is made in response to your letter dated 8th March 2010 in which you sought permission to visit our hospital to identify participants for your research study. This office therefore grants permission to you to proceed with your research study.

We would also be very grateful to you if you could share with us the findings of your final study.

Wishing you all the best and good luck.

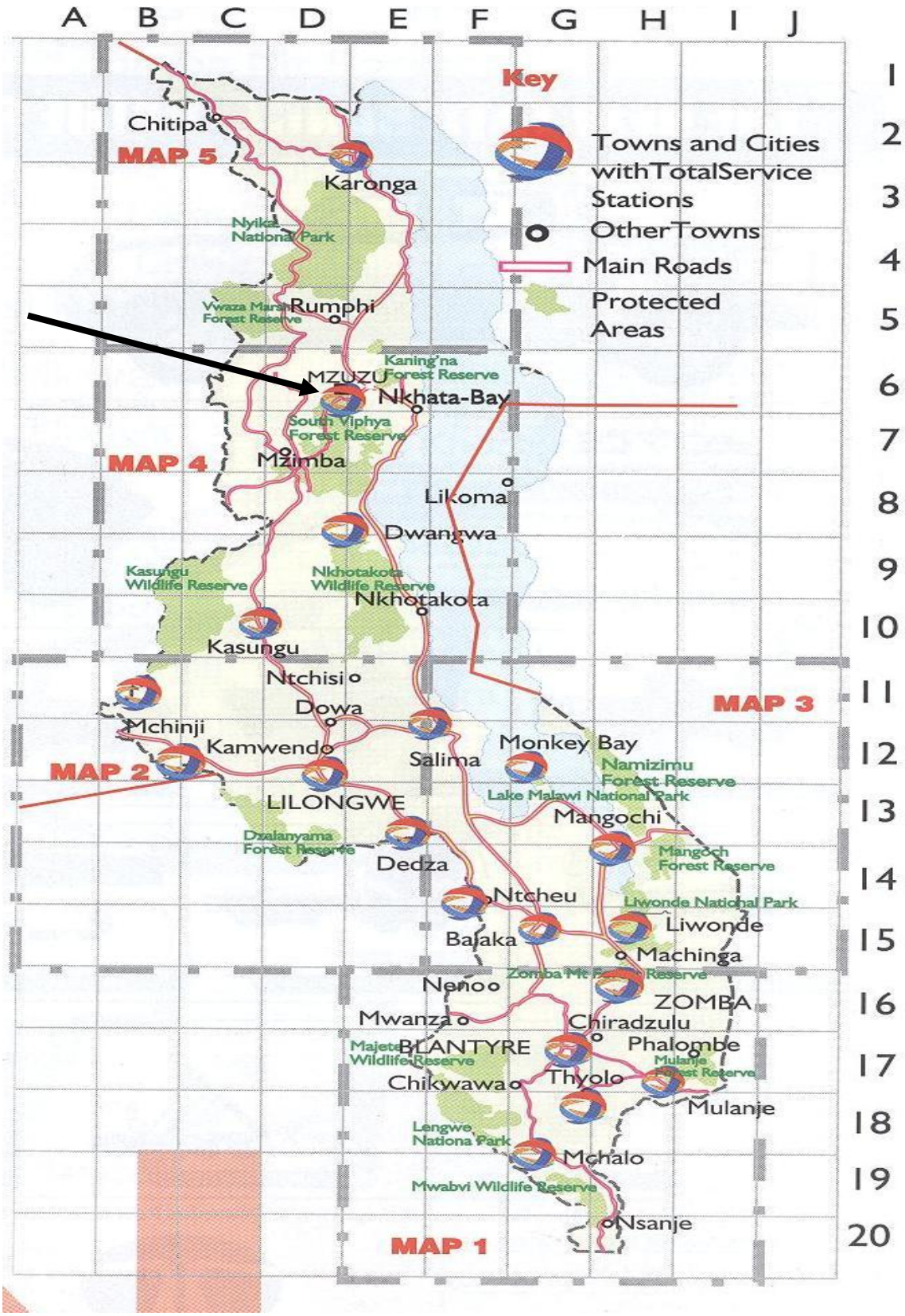
Yours faithfully



THE DISTRICT NURSING OFFICER
MZIMBA NORTH DISTRICT HEALTH OFFICE
08 MAR 2010
P.O. BOX 299, MZUZU

PP Dr HE Mzinganjira
DISTRICT HEALTH OFFICER

APPENDIX K: MAP OF MALAWI SHOWING LOCATION OF MZUZU CITY



APPENDIX L: MAP OF MZUZU CITY