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Beyond birth: Women's concerns about post-birth care in an Australian urban community

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ABSTRACT

Background: The provision of post-birth care in the community is changing substantially in many parts of Australia including Queensland, where there has been a burgeoning of clinics in private retail outlets such as pharmacies. Little is known about women's experiences of post-birth care in community pharmacies, nor of how their experiences compare with those in publicly-funded Child and Family Health Clinics (CFHC).

Aim: To provide qualitative insights into women's experiences of the different forms of post-birth care in the community, and identify where improvements could be made to service provision.

Methods: A purposive sample of mothers of infants aged under 12 months was recruited to maximise variation in the use of private and public postnatal care services. Semi structured interviews were conducted with fifteen mothers whose antenatal, birthing and post-birth experiences varied across public and private sectors and birthing providers.

Results: Concerns about lack of information and psychosocial support following discharge from hospital were widely reported, particularly by women who had given birth in a private facility under the care of a private obstetrician. Women used both pharmacy nurses and CFHCs. Pharmacy nurses were generally preferred for their accessibility, psychosocial support for mother, and continuity of care. However, these services are unregulated and without quality assurance mechanisms. Mothers found CFHCs regimented, focused on infant surveillance rather than support for mothers, and difficult to access.

Conclusion: There is a clear need for community post-birth care that will provide mothers with the information and psychosocial support they need. Currently, private, home-birth midwives and pharmacy nurses are providing women-centred care more effectively than nurses in publicly funded CFHC or GPs. This seems to be linked to continuity of carer, and to service priorities, resulting in inequities and systematic variations in the quality of post-birth care. Further research on this important health care issue is recommended.

1. Introduction

It is widely recognised that the first twelve months after giving birth is a period of increased morbidity for mothers,[1–3] yet approaches to providing care to newly parenting women are widely variable and changing rapidly. In particular, the length of stay in hospital following childbirth has decreased substantially in well-resourced countries, putting increased demand on care in the community, and the processes for transitioning care from hospital to home and community.[4–7]

Previous research in Australia has consistently shown that newly parenting women's experiences are characterised by unmet needs, dissatisfaction, and confusion about where to get help as they transition to new motherhood.[8,9] Considerably less is known about the factors that contribute to Australian women's experiences of care in the community following childbirth, especially women under the care of private obstetricians and midwives.

In Australia, maternity care is available to women through either the universal, publicly funded health system or through the parallel private health sector. Approximately 30% of Australian women give birth in private birthing facilities under the care of a private obstetrician; these women stay in hospital approximately

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twice as long as those in public facilities (median of 4 days compared with 2 days).[4] However, private sector facilities rarely have systems for post-discharge follow up.[10] Post-birth care in the community is available for free to all Australian parents through publicly financed child and family health clinics (CFHCs) and services. However research suggests that these services are inconsistent and fragmented, and often do not meet the needs of the population.[11] In Queensland, this has occurred in the context of fiscal policies of cost containment, and what has been described as a shift towards neoliberal policies that stressed individual responsibility for care and reliance on market forces.[12,13] Between 1995 and 2006, the number of public maternity services is estimated to have decreased substantially, from 84 to 36.[14]

In addition, significant gaps in service continuity have been identified in the transition of care from maternity to child and family health services Australia-wide; these are particularly problematic for women who birth in the private sector because of the limited interface between private and public health systems.[7,15] This national problem is exacerbated in Queensland, where the current policy guiding care following discharge from hospital, the Universal Postnatal Contact Services Program (UPNCS), does not include private health services.[16]

Recent quantitative studies reveal substantial systematic differences in the likelihood of follow up at home for women who give birth in public and private facilities,[5] as well as in women's satisfaction with care following discharge from hospital.[17] Recent qualitative research illustrates the nature of the differences in public and private sector women's experiences of post-birth care, both in hospital and in the community, with private sector mothers much more likely to raise concerns about post-discharge follow up.[18]

The significant retractions to state-funded services have spawned ad hoc market-based responses to help fill this service gap.[19,20] In Queensland, nurses employed by pharmacies in retail outlets ('pharmacy nurses') have become increasingly important providers of care and support to newly parenting women. Pharmacy nurses' clinics currently substantially outnumber CFHCs: for example, there were 56 pharmacy clinics and 10 CFHCs in the Brisbane City Council area in 2010.[20] Typically, these clinics are run by one nurse (thereby offering continuity of carer), operate out of relatively conveniently located shopping centres (usually easily accessible by public transport), and mainly function on a 'drop-in' rather than appointment basis.

A recent study of pharmacy nurses in Brisbane, Queensland, found that all were registered nurses, with most also having qualifications in midwifery; only about half had qualifications in child and family health, and many of these had experience in CFHCs. Most had extensive work histories (15 years or more), but at the time of the study the vast majority worked very short part-time hours (less than 15 h per week) in the pharmacy.[20] Pharmacy nurses themselves report high levels of demand for their services, and attribute the demand to the retrenchment of publicly provided CFHCs. Most work in a relatively public space, often at a table positioned near the 'baby goods' section of the pharmacy. Pharmacy nurses report concerns about lack of privacy for consultations, limited capacity to 'bare weigh' infants or for client record keeping and follow up, and rarely make formal referrals to other agencies or health care providers. In this context, their work focuses largely on woman centred-care such as maternal reassurance and support, even though they do weigh and to some extent monitor infants.[19,20] Their clinics are generally run on a drop-in basis, which provides some flexibility to mothers.[20]

At the same time as the number of pharmacy based clinics has been growing, the number of CFHCs has declined, become more geographically concentrated and less accessible. Most CFHCs operate on a 'by appointment' basis, often with waiting periods of several weeks. As a result, publicly funded clinics are currently failing to provide services that adequately meet the needs of mothers.[21]

To date, there has been little examination of the motivations and experiences of newly parenting women who use the services of pharmacy nurses. It is not known how women who use this service experience care in the post-birth period, or how their experiences compare with the experiences of women who use other services such as CFHCs. In this paper, we begin to fill this knowledge gap through the analysis of the experiences of women purposefully selected because of the differences or variation in their post-birth care.

2. Study and methods

A purposive sampling strategy was used to ensure the recruitment of women who had accessed private and/or publicly provided services.[22] CFHCs and pharmacies that employed nurses within a designated geographic area of Brisbane were identified and contacted. The study was described to child health nurses, nursing managers, pharmacy owners or pharmacy nurses, who promoted the study to their clients. This included displaying and/or distributing flyers or information sheets. Information about the study was also distributed through the Queensland Centre for Mothers and Babies existing email database; this further extended the variation in the experiences of the sample, and contributed to the inclusion of mothers who had not used either CFHCs or pharmacy nurses.

Face-to-face, semi-structured interviews were conducted with 15 mothers of infants under the age of 12 months throughout June and July of 2012. Informed consent was obtained from all participants and research ethics approval for the study was obtained by the University of Queensland (UQ) and the UQ School of Social Science Ethical Review Panels. Interviews were between 30 and 60 min in length and each interview was audio recorded and transcribed verbatim. Participants were asked about their experiences of all forms of post-birth care, through questions such as: Could you talk about the first few days after you gave birth? Could you talk about which services you have used to get help since your baby has been home? How have these services helped you? Participants also completed a demographic information sheet.

All interviews were transcribed, read and discussed by the first two authors, resulting in an initial identification of major themes through an open coding strategy.[23,24] Interviews continued to be conducted and open coding undertaken until no new major themes emerged and theoretical saturation was reached. All authors were involved in the identifying the key themes relating to the care gaps identified by the participants. NVivo 9 was used to assist with the management and analysis of verbatim text related to the thematic nodes. An interpretive methodology enabled a detailed exploration of the quality of women's experiences and the factors shaping their patterns of care use.

To ensure anonymity and confidentiality, data were kept securely on password-protected devices, and all questionnaire and interview data were de-identified. To protect the identities of participants, all have been assigned pseudonyms below.

3. Results

3.1. Participants' profiles

A summary of the key characteristics of the participants is provided in Table 1. They were aged between 25 and 43 years, with a mean age of 34 years. Three women were born outside of Australia, and all women lived with a partner or husband. Their educational backgrounds varied: two women were educated to