Understanding and Meeting the Needs of Women in the Postpartum Period: The Perinatal Maternal Health Promotion Model

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A new model for the care of women in the postpartum focuses on the development of life skills that promote complete well-being. The year following childbirth is a time of significant transition for women. In addition to the physiologic changes associated with the postpartum period, a woman undergoes marked psychosocial changes as she transitions into a motherhood role, reestablishes relationships, and works to meet the physical and emotional needs of her infant and other family members. It is a time when women are vulnerable to health problems directly related to childbirth and to compromised self-care, which can manifest in the development or reestablishment of unhealthy behaviors such as smoking and a sedentary lifestyle. In addition to long-term implications for women, compromised maternal health in the postpartum period is associated with suboptimal health and developmental outcomes for infants. Maternal health experts have called for a change in how care is provided for women in the postpartum period. This article presents the rationale for a health promotion approach to meeting the needs of women in the postpartum period and introduces the Perinatal Maternal Health Promotion Model. This conceptual framework is built around a definition of maternal well-being that asserts that health goes beyond merely the absence of medical complications. In the model, the core elements of a healthy postpartum are identified and include not only physical recovery but also the ability to meet individual needs and successfully transition into motherhood. These goals can best be achieved by helping women develop or strengthen 4 key individual health-promoting skills: the ability to mobilize social support, self-efficacy, positive coping strategies, and realistic expectations. While the model focuses on the woman, the health promotion approach takes into account that maternal health in this critical period affects and is affected by her family, social network, and community. Clinical implications of the model are addressed, including specific health promotion strategies that clinicians can readily incorporate into antepartum and postpartum care.

Keywords: patient education, postpartum care, postpartum depression, preventive health care, public health

INTRODUCTION AND BACKGROUND

The postpartum period, as defined in the biomedical literature, is the 6- to 8-week time period beginning an hour following the birth of the fetus and expulsion of the placenta and reflects the approximate time required for uterine involution and return of most maternal body systems to a nonpregnant state. However, reproductive system involution and the reestablishing of nonpregnant physiology are not the only critical events occurring in the months following childbirth. The postpartum period is also characterized by psychosocial adaptations, including changes in parental role,1,2 changes in family relationships,3,4 and alterations in self-perception and body image,1,4,5 many of which take significantly longer than 6 to 8 weeks to resolve. These transitions, coupled with the physical recovery from childbirth and the work that is required to meet the needs of an infant, make the year that follows the birth of a child a time of heightened vulnerability to health problems for women. Evidence suggests that, if unmitigated, the stressors of the postpartum period can lead to anxiety,6 fatigue,7 and decreased self-care,8 which are factors associated with an increased risk of physical and mental illness—including postpartum depression.9,10 Maternal mental and physical health problems are in turn associated with an increased risk of a multitude of poor health outcomes for the entire household, including early breastfeeding discontinuation, negative maternal perception of her infant, delayed child language acquisition, compromised maternal–child attachment, decreased childhood immunizations, and increased child behavioral problems.11–13

Given the potential long-term impact of compromised maternal health for the long-term well-being of the woman and her family, it is not a surprise that maternal health experts have called for optimizing women’s health in the year following childbirth.14–16 Despite these calls, the health of women during the postpartum period remains a neglected aspect of health care that has been the subject of comparatively little research, policy, and clinical attention. Therefore, it is not surprising that many women report that their health concerns are not adequately addressed in the course of their routine postpartum care.17 In the United States, this care typically consists of 2 to 3 days in the hospital following the birth, followed by a postpartum visit 3 to 8 weeks later that focuses on screening for and managing complications, assessing for reproductive organ involution, and the initiation of contraception. In the last few years, there has been increased scrutiny regarding the effectiveness of this care in terms of a holistic approach to addressing the needs of women during this critical period.11,15,18,19

The prevention, detection, and management of medical complications of the postpartum period are, and should con-
The year that follows childbirth is a time of immense physical and psychosocial transition for women during which women are vulnerable to compromised health not only from causes directly related to childbirth but also from decreased self-care related to the demands of new motherhood.

Optimizing the health of women in the year following childbirth requires a shift from a disease screening and treatment approach to a health promotion approach that focuses on strengthening 4 life skills that have been demonstrated to promote health: mobilization of social support, positive coping skills, self-efficacy, and realistic expectations.

These life skills promote health directly by leading to improved health-seeking behaviors and indirectly by serving as buffers from the stressors of this time period.

Clinicians can help women enhance these life skills through targeted educational messages, activities, and referrals during the antepartum and perinatal period.

HEALTH PROMOTION

Three core concepts distinguish a health promotion approach. The first tenet is the perspective of health as a state of well-being, which is the capability to engage in developmentally appropriate physical, psychological, and social tasks to one’s fullest potential. Within this perspective, well-being is different than simply the absence of disease or disorder. From a health promotion perspective, individuals are not healthy unless they are living to their fullest potential. Well-being is in part predicated on the learning and adoption of skills and traits that buffer the individual from disease-inducing events and situations. For example, a key protective factor is the competence by which individuals navigate stressful life events, relationships, and experiences.

The second tenet of health promotion is universal application. The premise of this approach is that every individual can benefit from improved functioning, and thus from promotion of well-being in all people. This approach circumvents problems associated with inaccuracies in classification of women’s risk status and errors in prognosticating women’s future health status based on these risk factors. For example, not every woman who is diagnosed as depressed is truly depressed and not every woman who is correctly diagnosed with depression has a poor prognosis. Similarly, some women without risk factors will develop postpartum depression (PPD), while others will have some signs of depression but will not cross the threshold by which an intervention may be triggered, such as a particular score on the Edinburgh Postpartum Depression Scale. By undertaking health promotion efforts to help all women to achieve effective coping skills and activation of a woman's social network, clinicians have the potential to reduce the overall incidence of maternal depression, including among those who may not have any observable risk for depression or who are below the diagnostic thresholds. Moreover, where a large population is experiencing heightened vulnerability, such as the 4.1 million women who give birth in the United States each year, even a low prevalence of a condition will lead to a large number of affected women. An intervention that lowers the prevalence of postpartum depression in the United States from 13% to 10%, for example, would prevent 123,000 cases of PPD annually.

The third tenet of health promotion is the importance of contextual influences. Within this perspective, individuals’ well-being is best viewed within the context of the family, and the family within the context of its community. Contextual factors, such as family members’ misunderstanding of psychological issues and the social milieu (eg, the social stigma of suffering from depression), have long been recognized as deterrents for seeking treatment. Health can thus be promoted by amplifying the positive contextual influences and reducing the social barriers to help-seeking. Individual-level efforts do not address the contextual issues that, in addition to decreasing the probability that such efforts will be successful, leave future generations vulnerable to the same risks facing the present generation. To the extent that changes in the social milieu are lasting, programs that work to change these contextual influences also promote the health of future generations.

PERINATAL MATERNAL HEALTH PROMOTION MODEL

The model introduced here and presented visually in Figure 1 was created in response to calls for a change in the approach to the postpartum period. It applies health promotion concepts and provides a framework for understanding both the factors that correlate with a successful maternal transition and how to translate this understanding into practice.

At the center of the model are key components of a healthy postpartum period: 1) physical recovery from pregnancy and childbirth; 2) meeting the needs of the mother (including social needs), infant, and other family members; and 3) successful attainment of the maternal role. The next layer of the
Table 1. Common Postpartum Complications: Prevention and Management

<table>
<thead>
<tr>
<th>Complication</th>
<th>Preventive Strategies</th>
<th>Management</th>
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<tbody>
<tr>
<td>Excessive bleeding</td>
<td>Conduct active management of the third stage of labor;</td>
<td>Evaluate to find cause (eg, uterine atony, retained products of conception, lacerations, hematoma, coagulation disorder/anticoagulation treatment) and treat accordingly.</td>
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<td></td>
<td>avoid traction on cord in third stage until signs of placental detachment; minimize operative birth and episiotomy; monitor anticoagulation therapy closely.</td>
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<tr>
<td>Infection</td>
<td>Endometritis: Minimize number of vaginal examinations during labor; provide prophylactic antibiotics 20-30 minutes prior to cesarean; avoid manual removal of placenta and manual exploration of uterus.</td>
<td>Obtain a culture and sensitivity if indicated; prescribe antibiotic therapy as indicated; recommend antiinflammatories and other pain relief measures as needed. If mastitis occurs, instruct woman to continue to breastfeed/pump.</td>
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<td></td>
<td>Urinary tract infection: Avoid/minimize catheterization; promote voiding following birth.</td>
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<tr>
<td></td>
<td>Episiotomy/laceration infection: Avoid episiotomy; utilize appropriate repair techniques; promote sitz baths.</td>
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<tr>
<td></td>
<td>Mastitis: Promote frequent and regular breastfeeding/pumping (8-12 times per day); provide assistance with latch-on techniques.</td>
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<tr>
<td>Depression</td>
<td>Promote social support; screen for and treat antepartum depression.</td>
<td>Screen all women using a validated tool; initiate antidepressants if indicated; contract for safety; provide referral to psychiatric care.</td>
</tr>
<tr>
<td>Thyroid dysfunction</td>
<td>Promote euthyroid state in pregnancy for women with preexisting thyroid disease.</td>
<td>Screen/test symptomatic women; treat accordingly.</td>
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<tr>
<td>Venous thromboembolic event</td>
<td>Avoid prolonged immobilization; compression boots if indicated; early postpartum ambulation; prophylactic anticoagulation if indicated; delay of combined hormonal contraception until &gt; 21 days postpartum (&gt; 42 if other risks of VTE).</td>
<td>Anticoagulation therapy; screening for thrombophilia.</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>Promote pelvic floor exercises; avoid operative birth; avoid episiotomy.</td>
<td>Rule out UTI; evaluate for cystocele and uterine prolapse; pelvic floor exercises; referral to urogynecology if problem persists.</td>
</tr>
</tbody>
</table>

Abbreviations: UTI, urinary tract infection; VTE, venous thromboembolic event.
Adapted from Thung and Norwitz.15

The model contains the key individual skills associated with the improved ability of women to achieve the goals of the postpartum. These four distinct but interrelated skills are 1) effective mobilization of social support, 2) self-efficacy, 3) positive coping, and 4) realistic expectations and goal setting. Finally, on the outside layer of the model are external resources that may be necessary for a healthy postpartum period. These include access to clinical services, social and other support services, information, and material resources such as food and housing.

Each of the model components is explained in more detail below.

**Core Elements of a Healthy Postpartum**

The key components of a healthy postpartum have been grouped into 3 categories in the model. These categories have important distinguishing characteristics, but they are intricately interrelated and overlap. The ability to meet the goals in one area can determine whether or not goals in another area can be achieved.

**Physical Recovery From Pregnancy and Childbirth**

Assessing for normal reproductive system involution (eg, return of the uterus to nonpregnant size, complete shedding of the pregnant decidua) and the reestablishment of the nonpregnant physiology (eg, normalization of glucose metabolism, return to baseline blood pressure) is the traditional focus of the routine postpartum visit with health care providers. There is some variation among women in how long most body systems take in returning to a nonpregnant state, but for most women this will have taken place by 6 to 8 weeks postpartum. However, while most women’s bodies return to what is considered nonpregnant anatomy and physiology within 2 months, results of population-based surveys of women in the
postpartum period reveal that many women have physical concerns directly related to pregnancy or childbirth at 3, 6, and even 12 months postpartum.25–28 The most common concerns expressed by women in these surveys are summarized in Table 2. For many women, these concerns are significant enough to interfere with activities of daily living and/or with their relationships with others, yet many of them do not seek help from providers.25–28 Because of this high prevalence of unaddressed health concerns, the postpartum period has been referred to as a time of “hidden morbidity.”27 From a health promotion perspective, successful interventions to address these health concerns would be aimed not at increasing the frequency of contacts with the health care system for all women, as has sometimes been proposed, but at helping women acquire the knowledge and skills to mobilize available resources to prevent or address health concerns, including the ability to seek care when necessary.

### Ability to Meet Individual Needs

Pregnancy and the peripartum are a time of transition in which nearly every aspect of a woman’s life is disrupted. During the postpartum period, a woman faces the task of adjusting to these transitions and reestablishing balance, routines, and relationships. During the first few days to weeks following the birth of a child, a key concern of women is the ability to take care of their own basic needs for sleep, eating, and hygiene.20 It is common, however, for providers to focus their education, assessment, and support during this time period on the newborn’s needs and not the woman’s.16 Women also frequently ignore concerns for their own well-being in order to focus their attention on the needs of their infant and family. Neglect by a woman of her needs during this period can lay the roots for compromised health for herself and her family in the long term. Research shows that the postpartum period is a time of heightened risk for compromised self-care and for the development or resumption of unhealthy behaviors such as smoking, inactivity, and poor diet.16 About one-third of mothers report that during the first 2 months their postpartum physical health or emotional health interfered at least “some” with their ability to care for their infant, with 42% of all mothers reporting physical and/or emotional impairment.26 Unmitigated fatigue and sleep disruption during the postpartum period is associated with multiple morbidities, including PPD,30 which in turn are associated with a disrupted transition to parenting and compromised outcomes for the infant and other members of a woman’s family.31 Providers should reassure women that it is normal to be concerned with their own well-being, and that addressing their own basic needs in the postpartum period is essential to their long-term health and the health of their families.

### Maternal Role Attainment

A major goal of the postpartum period is for women to successfully transition into their role as mothers. This developmental process that is alternately referred to as maternal role attainment, maternal role development, or becoming a mother is extensively described and discussed in the literature on motherhood.1,32 Becoming a mother requires a woman to redefine her sense of self through a restructuring of goals, behaviors, and responsibilities. The ability of a woman to form an attachment and care for each of her children depends on her ability to meet the developmental tasks or stages of this process. Various models have built on Rubin’s initial description of the progressive stages of the process of transitioning into motherhood. A brief description of key tasks of postpartum maternal role attainment as initially described by Rubin is included in Table 3. Support of these psychosocial processes should be an element of care of women during this important life transition.

### Individual Health-Enhancing Skills

Four skills consistently emerge in the literature as necessary for women to successfully exercise control over their health and the health of their infants and other family members in the postpartum period: effective mobilization of social support, self-efficacy, positive coping, and the setting of realistic expectations and goals.

### Effective Mobilization of Social Support

Social support is the assistance that individuals provide and receive from others. The role of social support in health behaviors and outcomes has been studied extensively. Social support provided by close relations and professionals appears to have a positive effect on physical health and psychological well-being; a lack of social support is associated with unhealthy behaviors such as smoking and a sedentary lifestyle.33–35 In the postpartum period, social support can be broadly divided into 2 categories: emotional support and instrumental support. Emotional support is what individuals do or say to make other individuals feel loved, supported, or encouraged. Instrumental support is when individuals provide needed material resources or assist with or complete a task for another individual. A third category of support, informational support, is sometimes mentioned in the literature. Informational support is included in the model as an external or enabling

**Table 2. Common Concerns of Women in Postpartum Period**

<table>
<thead>
<tr>
<th>Physical</th>
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<tbody>
<tr>
<td>Fatigue and sleep disturbances</td>
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<tr>
<td>Pain (perineal, incisional, breast, nipple, head, and back)</td>
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<tr>
<td>Self-care (hygiene, nutrition, weight loss)</td>
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<tr>
<td>Psychosocial</td>
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<tr>
<td>Maternal role attainment and attachment to infant</td>
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<tr>
<td>Body self-image</td>
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<tr>
<td>Marital/intimate relationship disruption</td>
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<tr>
<td>Care of infant, house, and family</td>
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<tr>
<td>Infant needs (feeding, soothing, identification of signs and symptoms of illness)</td>
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<tr>
<td>House maintenance (cooking, cleaning)</td>
</tr>
<tr>
<td>Needs of other children</td>
</tr>
<tr>
<td>Household logistics (transportation, childcare)</td>
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Rubin’s Phases of Maternal Role Attainment

Taking In: Mother focused on own needs and may need to tell and retell birth story; may take some time accepting newborn as “hers”; may not feel maternal and may seem passive in maternal role; may not be very responsive to attempts by others to get her to take on active role in newborn care; may not internalize educational messages.

Taking Hold: At about day 3, mother will become very interested in taking charge of newborn care; may seek perfection in her maternal caregiver role and is vulnerable to feelings of inadequacy; may become anxious and preoccupied with ensuring that she is doing everything right; will be open to education, but this needs to be provided in a way that does not erode her feelings of self-efficacy.

Letting Go: Mother may go through broad range of emotions from despondency to euphoria as she comes to accept the significance of her new maternal role and lets go of her old self to accept this “new normal.”

Source: Attrill.11

Figure 1. The Perinatal Maternal Health Promotion Model

Note: The 3 inner circles are the key maternal tasks of a healthy postpartum period. The ring around these tasks includes the core individual skills that are needed to ensure that the tasks are successfully accomplished. The outer ring represents resources that a woman may need in order to successfully acquire or employ her individual skills in order to accomplish the tasks of the postpartum, which include access to clinical services, social and other support services, information, and material resources.

factor rather than an individual skill. In addition to the direct effects of receiving instrumental assistance with tasks, social support is also thought to impact health positively by reducing the degree to which life events are perceived as stressful by an individual and by enhancing feelings of self-esteem and self-efficacy.36 The ameliorating effect of social support on perceptions of stressful events is often referred to as a “buffering effect.”37

Social support emerges as a key need of women during the postpartum period. Women express a need for both emotional and instrumental support; however, they may prioritize the need for instrumental assistance, especially during the first few postpartum weeks following the postpartum period. Throughout this time period, women report a need for assistance with infant, child, and household care so that they can complete basic tasks of self-care such as bathing, eating, and sleeping.29 Assistance with cleaning and cooking are also given high priority. Women report anger, stress, and anxiety when they perceive that others are failing to meet their need for support.35 Particularly stressful to women appears to be a dissonance between the support she expects to receive and the amount of support she perceives to receive.35,38 This finding that the perceptions of the support received can be as important as the actual support received is consistent with findings by researchers in other fields of health.33 How social support is mobilized, the perception of who should provide this support, and the degree of support that is expected may vary by race and ethnicity.29

Women from some ethnic or racial groups may be more likely to rely on their social network for assistance in the postpartum period. These women may be more likely to feel frustrated when their social network fails to meet their needs, whereas other groups of women may be less likely to involve anyone in their social network other than their partner in the
Barriers to effective mobilization of social support in the postpartum include maternal perceptions that asking for help will reflect poorly on her parenting abilities, fears of being perceived as a burden, fear of hurting people's feelings (eg, by asking for instrumental assistance different than what is being offered), and a perception that others would not be able to relate to her experience and thus not be able to offer adequate support. Helping women overcome these barriers can be a key intervention by health care providers that helps promote postpartum health.

Self-Efficacy
In Bandura's classic definition, self-efficacy is a person's beliefs in their ability to perform a particular behavior successfully. An expanded definition of self-efficacy as an individual's ability to achieve goals has been proposed by others and is used here. In the postpartum period, self-efficacy is positively related to health-seeking behaviors and inversely related to maternal stress and depression. Self-efficacy is also a key skill in maternal role attainment and a woman's ability to competently perform infant care and other parenting tasks that depend on her confidence in her mothering abilities. Maternal self-efficacy is also closely linked to child development.

Direct experience with a task or similar tasks strongly influences self-efficacy. This is reflected in findings that multiparas have a higher level of self-efficacy than primiparas and that maternal self-efficacy increases as the postpartum period progresses. While direct experience with a task has the strongest correlation with ratings of self-efficacy, vicarious experiences (seeing others perform the task) are also associated with increased self-efficacy.

Another important determinant of maternal self-efficacy in the postpartum period is infant temperament. Women with infants who are difficult to soothe lose confidence in their ability to take care of their infants' needs and are more likely to report fewer efforts to soothe their infant. This highlights an important snowball effect of self-efficacy: when confronted with a difficult task, individuals with lower self-efficacy will avoid or give up more easily, which in turn further decreases their self-efficacy. Alternately, success at a task that is important or difficult enhances self-efficacy and improves the probability that an individual will persist at a task, even when it becomes difficult.

Positive Coping
Although sometimes defined as an adaptive response by an organism to adverse circumstances, from a human behavioral perspective, coping can best be defined as an effort to manage and overcome demands or experiences that pose a challenge or a threat of harm, loss, or benefit to a person. Coping can occur in response to (reactive) or in anticipation of (proactive) demands or problems. Coping strategies can be divided into 3 broad categories: appraisal-focused coping, problem-focused coping, and emotion-focused coping. Individuals can modify the way that they think about the problem/stressor, such as by redefining or accepting the stressful situation. These are appraisal-focused strategies. Individuals can also cope by taking direct action to change the situation by reducing or eliminating the stressor. This is known as problem-focused coping. Individuals may also purposefully change the way in which they react to a stressor, using strategies such as meditation, relaxation, or prayer. These are examples of emotion-focused coping strategies.

Coping seems to be a highly individualized response dependent on the nature of the situation and disposition of the people involved. Women use a variety of coping strategies to deal with the stressors of the postpartum period. However, several common themes emerge regarding coping in the time following childbirth. Reaching out for social support is a positive coping strategy, particularly in the early postpartum period. Unfortunately, women also tend to use negative coping strategies such as avoidance or minimization to deal with issues related to their own health in the postpartum period. This is consistent with findings that many maternal health problems in the postpartum period go unaddressed.

Realistic Expectations
The development of expectations is a normal adaptive human response that helps modulate individual behavior and allow for efficient and effective interpersonal interactions. However, when expectations are based on incomplete or incorrect information and conflict with the reality of a situation, the dissonance that results can be disruptive to the individual and to relationships. Whether or not expectations are met in the postpartum period affects a woman's ability to adjust to motherhood and to other transitions following childbirth. Similarly, women who report feeling unprepared for the postpartum period may be at increased risk for postpartum depressive symptoms, physical ailments, and functional limitations. In addition, postpartum adjustment is rated as more difficult by women whose experiences are worse than what they expected. Unmet expectations regarding parenting tasks are associated with compromised ability to cope, increased maternal distress, increased marital disruption, and decreased ability to effectively mobilize social support. Previous experience with a task or a similar situation and accurate and timely information are associated with a better match between expectations and reality. Finding ways for women, particularly those expecting their first child, to practice some of the tasks of new parenthood, such as soothing a fussy infant, may help ameliorate some of the stress of this time period. Additional ways to promote the setting of realistic expectations and to support the other individual health-enhancing skills are described later in this article.

External Resources
In the outer layer of the model are the external resources that a woman may need for a healthy postpartum period, which include access to clinical services, social and other support services, information, and material resources (eg, food, shelter, medications, health insurance, infant care supplies). Many current interventions and policies aimed at increasing access to these resources were designed to focus on pregnancy and often only extend 6 to 8 weeks into the postpartum period, after which they disappear or become available only for the infant (eg, case management, home visitation, public
Table 4. Examples of Health Promotion Strategies for Clinicians

<table>
<thead>
<tr>
<th>Effective Mobilize Social Support</th>
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<tbody>
<tr>
<td>Helping the woman create and communicate concrete plans for the support she will need in the postpartum period may help the woman achieve the support she needs and make it more likely that she will have a positive perception of this support.</td>
</tr>
<tr>
<td>Ask the woman to identify specific tasks she will need support for, the members of her social support network, and what type of support she expects from her support network.</td>
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<tr>
<td>Let her (and support people if possible) know that she will need both emotional support (encouragement, positive feedback) and instrumental support (help with infant care and housekeeping).</td>
</tr>
<tr>
<td>Let her know that others may not be able to anticipate her needs and that if others fail to meet her needs this can cause anger or sadness.</td>
</tr>
<tr>
<td>To avoid this, encourage her to share her specific concrete requests with those to whom she has identified as her source of support.</td>
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<tr>
<th>Self-Efficacy</th>
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<tr>
<td>Key in this domain is to promote in the woman a sense of herself as capable of meeting demands of parenting.</td>
</tr>
<tr>
<td>Ask the woman about tasks that she foresees will be difficult for her in taking care of a newborn or herself in the postpartum period, and engage her in a quick troubleshooting session where she can create solutions to obstacles and challenges.</td>
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<td>Give her permission to “fail.” Remind her that her ability to accomplish tasks of parenting will not always be a reflection of her skills as a mother, but rather a variety of factors (such as infant temperament), only some of which she may be able to control.</td>
</tr>
<tr>
<td>Let her know that it is normal in the postpartum period to not feel immediately maternal toward her newborn. Providers do need to be aware, however, that a lack of maternal feelings that persists past 1-2 weeks may signal a problem such as depression.</td>
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<tr>
<td>Videos or demonstrations of others successfully completing tasks can be helpful as long as it seems feasible to the woman. The more the women in the video resembles the woman, the more she will be able to feel a sense that she too can achieve the skills or activities being demonstrated.</td>
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<th>Positive Coping</th>
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<td>The goal is to help the woman grow her positive coping skill armamentarium and minimize the use of negative coping skills.</td>
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<tr>
<td>Help the woman conduct a coping skills assessment by asking questions such as, “What sort of things do you do to cope or to manage a difficult problem?” “What are you going to do when you are so tired that you do not feel you can take care of your baby?” “Newborns cry a lot and that can be very stressful for new mothers. What are you going to do when your baby starts crying and you cannot get your baby to stop?”</td>
</tr>
<tr>
<td>Help her identify positive versus negative coping skills and what leads her to resort to one or the other.</td>
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<tr>
<td>Stress and anger management classes (even if they are not focused on pregnancy) may be a useful resource to refer a woman for.</td>
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<tr>
<td>Teach the woman about safe stepping-away techniques (eg, put infant in crib and walk away to catch her breath, time-outs for toddlers, 10 deep breaths). Have her identify some of these that she can use if she needs them.</td>
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<th>Realistic Expectations</th>
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<td>The main goal as providers in this arena is to better prepare the mother for the demands of the postpartum period. “A proactive, honest, reality-based approach aimed at altering maternal expectations of the postpartum could be directed at counteracting the feelings of inadequacy often experienced by new mothers.”</td>
</tr>
<tr>
<td>Normalize the experience of feeling overwhelmed and uncertain by letting her know that these are feelings that are almost universally expressed by women in this time period.</td>
</tr>
<tr>
<td>Provide information on wide variations of normal infant temperament including feeding, crying, and sleeping patterns.</td>
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<tr>
<td>Provide information on the fact that it is normal for it to take months, if not a year or more, for a woman to feel back to herself.</td>
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medical insurance). Helping to ensure availability of and access to these resources is an important component of health promotion for women.

In addition to clinical care and referrals for social and other services, midwives and other clinicians provide information and education to women. Timely and accurate information is often a critical resource in order for women to effectively utilize their individual health-promoting skills in the postpartum period. For example, a crying infant can be a source of anxiety and stress for a woman, which, if unmitigated, can increase the risk of depression or shaken-baby syndrome. In order to be able to effectively soothe her infant, a woman needs to know what strategies work best to make an infant stop crying, which is information that can be provided by clinicians. Similarly, a woman is also less likely to experience a loss of self-efficacy related to the crying if she understands the normal crying patterns for infants and the reasons infants cry. If a woman believes the crying is not due to a lack of skill on her part, but instead that it is an expected behavior, she will be more likely to attempt to soothe her infant, which
is an important activity to build trust—a key developmental milestone for infants.

While it is generally known that women want and need information to successfully transition in the postpartum period, the timing of when to deliver this information is not clear. While new parents often state feeling like they did not receive enough information to prepare them for the first weeks and months of parenthood, research also shows that parents who receive abundant information during antenatal classes have difficulties in assimilating information referring to the postpartum period. Providers must find and test ways to effectively transfer information regarding the postpartum to parents.

**CLINICAL IMPLICATIONS FOR MIDWIVES AND OTHER HEALTH CARE PROVIDERS**

A health promotion approach to maternal health in the postpartum period is one that is consistent with the philosophy of care of midwives that affirms “the power and strength of women and the importance of their health in the well-being of families, communities, and nations.” Philosophy, however, can often be difficult to operationalize. The model presented here is designed with the goal of helping transform philosophy into action by describing those elements that are the source of power and strength for women in the perinatal period and by providing specifics of how they can translate into health outcomes for herself and her family.

While this model can help guide the design of health promotion interventions at the policy or program level, a health promotion approach can also be implemented by the individual clinician during routine encounters with women during pregnancy and postpartum care. A health promotion approach at the provider–client level requires an understanding by the provider that the health needs of women in this time period include, but also extend beyond, the physical recovery from birth. Similarly, it means expanding the realm of interventions beyond those to increase contact with the health care system or to improve identification and treatment of morbidities. Adopting a health promotion approach to care means implementing strategies that enhance a woman’s internal skills that protect her from disease-inducing events, thus promoting her own ability to ensure her health, and in turn the health of her infant and other family members. Table 4 includes examples of health promotion strategies within each internal skills’ component of the model that providers can utilize in the clinical setting. The CenteringPregnancy model of care is an example of a program that deliberately and successfully has incorporated a health promotion approach. In the CenteringPregnancy model of group care, mobilization of social support, self-efficacy, and positive coping skills are all promoted explicitly as session goals and implicitly through the essential elements that guide its design.

The promotion of maternal health cannot end at the birth of the newborn, nor at the 6-week postpartum visit. Women have physical and emotional needs directly related to pregnancy and childbirth that take longer than 6 weeks to resolve. Furthermore, the long-term health of infants and children is extensively and intricately tied to the health of their mothers. The research evidence overwhelmingly suggests that a healthy postpartum period depends on the ability of a woman to effectively employ her own skills to ensure that her needs and the needs of her family are met. Midwives and other providers of care to women during this critical life transition have a duty to understand that the health needs of women during this time period extend beyond physical recuperation from childbirth and to find ways to incorporate strategies into care that will help women build their individual skills to successfully meet those needs.

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**CONFLICT OF INTEREST**

The authors have no conflicts of interest to disclose.

**REFERENCES**


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