Undoubtedly, optimal postpartum recovery is essential to ensure women’s physical and mental health, their ability to optimally care for their newborn(s), and their return to prepregnancy function and well-being, whether at work or at home. Much emphasis has been placed on developing enhanced recovery after cesarean protocols, including ways to prevent persistent opioid use; however, standardized tools to assess global postpartum recovery are still lacking. In a systematic review, Sultan and colleagues evaluated 46 prospective studies, involving 19,165 patients giving birth between 1988 and 2020, that used a variety of patient-reported outcome measures (PROMs).

Before delving further, understanding the methods and taxonomy are essential; the Consensus-Based Standards for the Selection of Health Measurement Instruments (COSMIN) method for systematic reviews of PROMs created an exhaustive checklist with criteria to evaluate the quality of PROMs and review the psychometric results and overall quality of measurement properties. The PROMs are to be regarded as “structured questionnaires allowing patients to report their health status” and are deemed the gold standard for assessing recovery after surgery. The domains of inpatient and outpatient postpartum recovery assessed in PROMs have so far included (1) general physical recovery, (2) medical or surgical factors (including complications such as genitourinary or gynecological and fecal incontinence), (3) anesthesia-related adverse events, (4) comfort and satisfaction, (5) pain, (6) psychosocial distress (including depression, anxiety, and other psychological morbidity), (7) psychosocial and patient support, (8) sleep, (9) fatigue, (10) motherhood experience (including adapting to the maternal role and motherhood experience), (11) sexual function, (12) feeding and breast health, (13) cognition, (14) appearance and cosmetic factors, and (15) infant health.

A recent scoping review conducted by Sultan and colleagues identified a total of 201 PROMs used to assess outpatient postpartum recovery and 73 PROMs used to assess inpatient postpartum recovery. Of the 13 domains identified, the 5 most studied domains of outpatient postpartum recovery were psychosocial distress (77 PROMs), surgical complications (26 PROMs), psychosocial support (27 PROMs), motherhood experience (16 PROMs), and (5) sexual function (13 PROMs), but the authors concluded that most PROMs evaluated only 1 domain of recovery and proposed that a multidimensional approach to assess global postpartum recovery is necessary. In another systematic review using the COSMIN checklist, Sultan and colleagues evaluated PROMs on the quality of immediate functional recovery after cesarean delivery. They identified 20 studies involving 9,214 patients using 13 different PROMs, each covering between 2 and 7 recovery domains. As emphasized by the authors, there was no high-quality PROM for use after cesarean delivery beyond 25 hours post partum, and the Obstetric Quality of Recovery (since modified to a 10-item version) performed best for assessing immediate inpatient postpartum recovery.

The novelty and significance in the present work by Sultan and colleagues lie in attempting to identify, using the COSMIN checklist, the best available multidomain PROMs assessing postpartum recovery beyond the delivery hospitalization; the goal is to provide a standardized framework by which maternal physical and emotional health will be adequately evaluated, enabling screening and intervention when women are not recovering, coping, or meeting expected milestones after childbirth. For a PROM to be included in this systematic review, it had to assess at least 3 of 13 domains to better capture the multidimensionality of postpartum recovery, and it had to include...
assessment of at least 1 of the 8 psychometric properties defined by the COSMIN criteria, which are
(1) structural validity (model fit of a factor analysis), (2) internal consistency (interrelatedness among
PROM items), (3) cross-cultural validity, (4) reliability (ability of a PROM to distinguish between
patients), (5) measurement error, (6) criterion validity, (7) hypothesis testing, and (8) responsiveness
(ability to detect change over time between 2 postpartum time points).

With these screening criteria, 15 PROMs were deemed eligible for inclusion in this analysis, of
which 7 are obstetric specific (used in 20 studies) and 8 are non–obstetric specific (used in 26
studies). Eight of the PROMs evaluated recovery only up to 2 months post partum but not beyond,
whereas 4 evaluated postpartum recovery up to 6 to 12 months, and 3 PROMs up to 5 years post
partum or even longer. The 3 best PROMs were deemed to be (1) the Maternal Concerns
Questionnaire (MCQ), a 51-item survey in English developed in 1995 that assesses 12 domains and
was further used in 1998 (n = 100); (2) the Postpartum Quality of Life (PQOL) instrument, a 40-item
survey developed in China in 2009 that assesses 9 domains and was validated in 1 study among
Iranian women at 8 weeks post partum (n = 500); and (3) the World Health Organization Quality of
Life-BREF score (WHOQOL-BREF), a 26-item non–obstetric-specific survey in English that assesses 9
domains and was validated in 1 Australian study evaluating women at 6 weeks post partum (n = 221).
Numerous shortcomings were identified and listed by the authors. For example, the MCQ, with weak
methods, does not evaluate sleep and has not been widely used or evaluated beyond 2 weeks post
partum; the PQOL, with robust methods and ease of use, has not yet been used in western cohorts,
and there are no data to inform its cross-cultural validity; the WHOQOL-BREF lacks reliability, and
relevant postpartum factors such as motherhood experience and breastfeeding are not assessed.

Sultan and colleagues have scoped, analyzed, reviewed, and deconstructed the available
literature on how to assess immediate and long-term postpartum recovery, and they have laid the
foundation for future work. We are forced to acknowledge that there is not 1 single valid, reliable,
and contextualized tool to evaluate how the 128 million women who give birth around the world
every year are and will be doing. Our current inability to adequately screen, detect, report, and
compare trajectories of postpartum recovery is disappointing given its public health relevance. The
staggering numbers related to maternal morbidity and disparities affecting the most vulnerable
communities in the past have worsened with the current pandemic.

We seem to be on the right path of finally recognizing the need for a context-specific, culturally
competent, patient-driven outcome measure tool for optimal postpartum recovery. The next step
is to identify all domains and specific items that will matter to patients, in their specific environment
and communities, being cognizant that this will definitely vary based on who they are (age,
comorbidities, and psychosocial construct), where they are (geographic and ethnocultural
constructs), what type of obstetrical delivery each had, how their infants are doing (planned vs
intrapartum potentially emergent delivery), and what matters to them (personal preferences and
beliefs). With those fundamental principles in mind, it has become urgent to design, validate, and
implement a contextualized postpartum recovery PROM that will assist clinicians and researchers
aiming to improve maternal health during childbirth and beyond.
REFERENCES