Research Update

Papers Presented at the 8th International Conference of Maternity Care Researchers

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Abstract

This column provides a brief overview of some of the papers and presentations offered at the 8th International Conference of Maternity Care Researchers, held September 2000 at the University of Glasgow in Scotland.

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International research meetings provide insight into critical issues that deal with the care of childbearing families from a world perspective. In September 2000, papers presented at the 8th International Conference of Maternity Care Researchers, which was held at the University of Glasgow, Scotland, were clearly related to issues of special interest to me as a childbirth educator and maternal-child nurse. All of the papers were presented in English; many were from the United Kingdom, Australia, New Zealand, Canada, and the United States, while Sweden, Hong Kong, and Japan were also represented. Excerpts from selected papers follows in the text below.

Choice, control, and continuity (the “three Cs”), along with involvement in decision-making, have become the language of maternity care in the United Kingdom since the publication of *Changing Childbirth* (Department of Health, 1993). This document represents official government policy. Prior to its publication, Green, Coupland, and Kitzinger published *Great Expectations* in 1987, a study that involved 700 women and covered all aspects of their care around birth. A key finding revealed that a sense of control was essential to psychological well-being. At the recent meeting in Glasgow, Green, Easton, and Baston presented a study that replicated *Great Ex-*

pectations. Their study involved 1,427 women and was designed to investigate the way in which expectations and experiences had changed in the intervening 13 years since *Great Expectations*. Women were recruited from both the original four districts and an additional four, demographically matched districts. Green, Easton, and Baston found that women did indeed seem to feel that they had more choice (87% in the 2000 study, compared to 48% in the 1987 study), but the researchers wondered if women always knew all of the options available to them. Analysis of these data is ongoing.

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Evidenced-based practice was another theme running through many papers and presentations at the Glasgow meeting. In their study, Calvert and Rowley described a New Zealand center for research designed to improve the quality and cost effectiveness of maternity and gynecological services. *Changing Childbirth* (Department of Health, 1993), the United Kingdom document described earlier, recommends that “[c]linical practice should be based on sound evidence and regular clinical audit” (p. 64). Using ethnography, Richens studied the complex, multifactorial barriers to accomplishing that goal. Barriers included attitudes, knowledge, beliefs, organizational and economic issues, and the influence of colleagues.

In two separate studies presented at the Glasgow meeting, women described themselves as feeling “marginalized” for very different reasons. Edwards presented a qualitative study of 30 women in England who were planning a home birth. While once common in England, home birth now accounts for only a small percentage of births. Each of the women in Edwards’ study participated in four in-depth interviews. They reported viewing home birth as a culturally marginalized activity. Most were given messages that home birth was “unsafe” and “weird.” Edwards found these women wanted midwives to be confident and competent and to focus on them as individuals, honor their beliefs and ideals, protect their vulnerability, and provide support for them and their families in order to move through birth with the least

harm and most benefit. The women did not want decisions made for them or anyone to steal away their experience.

Another paper presented in Glasgow revealed a second group of women who felt “marginalized”—those who chose to continue their pregnancy after the diagnosis of fetal abnormality. Green, Statham, and Solomou’s paper is part of an ongoing, longitudinal study being conducted at the Mother and Infant Research Unit at the University of Leeds in England. Most often, the abnormality was one amenable to some type of treatment after birth (e.g., facial clefting, gastroschisis, or a renal abnormality) and the chance of infant survival was strong. Nevertheless, women reported that, once the diagnosis was made, the attitudes towards the pregnancy changed. The authors stated that “the focus on the normality of pregnancy and childbirth that has determined many recent changes in the organization of maternity care may marginalize those women whose pregnancy becomes not normal.”

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Another paper discussed the measurement of perinatal outcomes in low-risk women is difficult if traditional criteria of maternal and infant mortality are used, because these occurrences are rare in this population. From McMaster University Midwifery Education Program in Ontario, Canada, McNiven, Kaufman, Keller, and Enkin argued that the *process* of care measures should also be a part of the evaluation of intrapartum and immediate postpartum care. Following a model from the Netherlands, McNiven and her colleagues modified the Dutch Perinatal Outcome Index for their population in Ontario, which included process-of-care measures. They reported the applicability, feasibility, content, concurrent and criterion validity, and reliability of the measure they developed. They believe the tool is now ready for use with their population.

In a randomized clinical trial from Lund, Sweden,

Dykes and Werntoft measured the effect of acupressure on nausea and vomiting during pregnancy. Twenty women were randomized to each of three groups. One group wore a wristband with a "button" providing acupressure at P6, a second group wore a placebo wristband, and a third group received no treatment. While no difference existed between the placebo group and the no-treatment group, the treatment group experienced significantly less nausea and vomiting at all data collection times (1, 3, 6, and 14 days after the initiation of treatment) compared to the other two groups.

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Controversy over the impact of birth position on perineal outcome is not limited to the United States, as demonstrated in a paper presented by an Australian team from Wollongong, New South Wales. A. Shorten, Don-sante, and B. Shorten reviewed birth registry data from 2,900 normal vaginal births. They found a significant relationship between birth position and perineal outcome. A lateral position in the second stage was the most favorable for an intact perineum, while squatting was the least favorable. The highest episiotomy rate was exhibited among women in a semi-recumbent position; these same women were also most likely to have had an obstetrician attending their births. Shorten and colleagues plan to study further the relationship between the *accoucher* (the professional attending the birth) and perineal outcome.

A study by Hall, Dykes, Dinwoodie, and Bramwell, from Lancashire, England, examined the effect of participation in the WHO/UNICEF 20-hour training program, "Breastfeeding Management: A Modular Course." This program focuses on knowledge, clinical skills, and attitude, and is designed to improve the breastfeeding support skills of midwives. Hall and colleagues used a previously validated tool, the BeSST, and selected midwives from four hospitals in the United Kingdom. They reported statistically significant improvement in the scores attained by midwives who completed the course,

compared to the scores of those who did not complete the course.

In her study about education provided during pregnancy, Lavender conducted semi-structural interviews with 80 women. Participants said they were either "bom-barded" with information, particularly on the first prenatal visit, or "neglected." Additionally, they stated that they "did not want to be shielded from reality." They also felt prepared for parenthood, until it became a reality.

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In a study of first-time fathers in Scotland, McElligott reported that fathers wanted more information about caring for their newborns. Similarly, Lee reported from Sydney, Australia, that male facilitators lead two antenatal classes for fathers only.

The opportunity to participate in an international research meeting and experience the commonality of interests is a cherished one. In the spring of 2002, the International Society of Maternity Care Researchers will meet in North America for the first time since the organization initially met in 1986 in the Canadian city of Calgary, Alberta. Since that time, meetings have been held in Jamaica, Sweden, Taiwan, Hawaii, Australia, Norway, and Scotland. Wake Forest University will host the 2002 meeting in North Carolina. Further details will appear in future issues of this journal.

References

- Department of Health. (1993). *Changing childbirth. Part 1. Report of the expert maternity group*. London, HMSO.
- Green, J., Coupland, V., & Kitzinger, J. (1998). *Great Expectations: A prospective study of women's expectations and experiences of childbirth* (2nd ed.). Hale, Cheshire: Books for Midwives Press.

Papers Described in This Column

- Calvert, S., & Rowley, M. *The Centre for Midwifery and Nursing Practice and Research at Capital Coast Health, Ltd.*

- Dykes, A. K., & Werntoft, E. *The effect of acupressure on nausea and vomiting in pregnancy.*
- Edwards, N. *From pregnancy to motherhood: What do women need?*
- Green, J., Easton, S., & Baston, H. *Greater expectations? A comparison of women's expectations and experiences of maternity care choices in 1987 and 2000.*
- Green, J., Statham, H., & Solomou, W. *The needs of women who continue a pregnancy with a confirmed fetal abnormality.*
- Hall, M., Dykes, F., Dinwoodie, K., & Bramwell, R. *An evaluation of midwifery skills acquisition following the WHO/UNICEF Breastfeeding Management Course.*
- Lavender, T. *Women's views of information received within maternity services: A longitudinal study.*
- Lee, J. *Including men in antenatal education.*
- McElligott, M.A.C. *Does midwife-led parenthood education meet the educational needs of first-time fathers?*
- McNiven, P., Kaufman, K., Keller, J., & Enkin, M. *Measuring perinatal outcomes for low-risk women: The Canadian perinatal outcome index.*
- Richens, Y. *Are midwives using evidence in practice?*
- Shorten, A., Donsante, J., & Shorten, B. *Birth position and perineal outcome: Can midwives make a difference?*

Study Finds That Violence against Pregnant Adolescents Increases Risk for Preterm Birth

Adolescents who experience prenatal violence may be at increased risk for poor birth outcomes, claims a study published in the January 2001 issue of the *Journal of Adolescent Health*. The authors' assessment of the consequences of prenatal violence on birth outcomes was based on self-reported data on prenatal violence from 545 Medicaid-eligible women ages 13 to 40 who participated in maternity-care-coordination services at a county health department in North Carolina from April 1994 to April 1996.

The study findings reported that 16.1% of the adolescents (ages 13 to 19) and 11.6% of the adults (ages 20 to 40) reported prenatal violence. Of those reporting a violent incidence:

- 35.7% of the adolescents and 21.8% of the adults reported multiple incidents of prenatal violence;
- 56.3% of the adolescents reported being injured in the abdomen, while 55.6% of the adults reported being injured in the head or face; and
- 61.3% of the adolescents and 87.8% of the adults reported being injured by a current or ex-partner.

Adolescents who reported severe violence were more likely to deliver a preterm infant, to deliver a low-birthweight preterm infant, to use alcohol, and to have had a prior preterm birth, compared with adolescents who reported other or no violence.

The authors note that the study's findings may be limited because the study did not distinguish between adolescents or adults who experienced moderate violence and those who experienced no violence and because the findings were based on self-reported violence. In addition, the authors were not able to screen for violence before and after pregnancy to compare the two.

The authors suggest that all women be screened for violence during pregnancy and directed to the appropriate services. They conclude that "teens may be more vulnerable to the consequences of prenatal violence. They may require interventions that can adequately address violence in their home and social environment in addition to violence by a romantic partner."

Covington, D. L., Justason, B. J., & Wright, L. N. (2001). Severity, manifestations, and consequences of violence among pregnant adolescents. *Journal of Adolescent Health* 28(1), 55-61.

The above news brief appeared in the January 12, 2001, issue of MCH Alert, which is produced by the National Center for Education in Maternal and Child health in Arlington, VA (www.ncemch.org/alert).

For more on pregnancy and violence, see two articles that were previously published in this journal:

Betts-Cobau, T., & Hoyer, P. P. (1997). Part I—Domestic Violence: Are professional pledges such as the "Nightingale Pledge" obsolete? *Journal of Perinatal Education*, 6(4), 18-27.

Gaines, K. A. (1997). Part II—Abuse and pregnancy: What every childbirth educator/nurse should know. *Journal of Perinatal Education*, 6(4), 28-34.