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- Midwifery students’ understanding and knowledge of normal birth
- Mifepristone in pregnancy termination
- Paternal postnatal depression in Ireland
- Complementary and alternative medicine for post-date pregnancy

**Abdissions used in this issue:**

- aOR = odds ratio
- aRR = adjusted relative risk
- BMI = body mass index
- OR = odds ratio.

**Welcome** to issue 13 of Midwifery Research Review.

Women and their infants who receive formula in hospital need additional support to attain exclusive breastfeeding by hospital discharge according to the findings of a retrospective cohort study of clinical data from five hospitals in New South Wales. Following on we review a study investigating the OnLNE intervention, a pilot intervention program aiming to limit postpartum weight retention and promote healthy diet and physical activity behaviours in new mothers, and discover encouraging feedback. Other studies in this issue address the topics of breastfeeding experiences of obese women, the midwife’s role in suicide prevention, skills and attributes for rural midwifery practice in New Zealand and Scotland, anxiety, depression and relationship satisfaction in the pregnancy following a stillbirth, midwifery students’ understanding and knowledge of normal birth prior to them starting their studies, mifepristone in pregnancy termination, paternal postnatal depression in Ireland, and the influence of midwives’ own experiences on their recommendations for complementary and alternative medicine for post-date pregnancy.

We hope you enjoy reading this review and look forward to your comments and feedback.

Kind Regards,

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**Formula supplementation in hospital and subsequent feeding at discharge among women who intended to exclusively breastfeed: An administrative data retrospective cohort study**

**Authors:** Bentley JP et al.

**Summary:** This retrospective cohort study of clinical data from five hospitals in New South Wales (NSW), Australia (2010-2013) investigated factors associated with in-hospital formula feeding among healthy term infants born to women who intended to exclusively breastfeed. Among 24,713 mother-infant dyads, 16.5% received formula in hospital. Breastfeeding difficulties (aRR 2.90; 95% CI 2.74-3.07), Asian born mother (aRR 2.07; 95% CI 1.92-2.23) and neonatal conditions (aRR 2.00; 95% CI 1.89-2.13) were identified as the strongest predictors of formula supplementation. Of the 3998 infants who received formula, 17.5% were formula-only feeding, 33.1% were partially breastfeeding, and 49.3% were fully breastfeeding at discharge. Factors most strongly associated with fully breastfeeding at discharge were special care nursery admission (aRR 1.23; 95% CI 1.17-1.30) and ≥1 neonatal conditions (compared with none; aRR 1.21; 95% CI 1.16-2.16).

**Comment (MS):** This small NSW-based population study examines the factors associated with in-hospital formula supplementation of infants whose mothers had intended to exclusively breastfeed their babies within public hospitals in NSW. Much of the information presented within this paper has been identified within previous studies as factors that influence the likelihood of exclusive breastfeeding - but the strength of this paper is as the author’s state, the fact that routinely collected data as opposed to recall data is used, therefore it is likely to be more accurate and enables patterns to be identified. Some factors that may be influencing the findings in this study though are unknown – for example the model of care the women had experienced, level of antenatal preparation and whether the birthing facility was an accredited Baby Friendly Hospital Initiative organisation. Additionally it would have been interesting if the figures included data from private hospitals. Midwives reading this paper can still however identify which characteristics are associated with supplementation and aim to promote practices that are likely to result in exclusive breastfeeding wherever they practice. For example ensuring women have access to good preparation prior to birth including information on positioning, attachment and supply. Ensuring women have access to uninterrupted skin-to-skin time following birth. Ensuring women receive consistent information and support when learning the skill of positioning and attachment. All midwives can contribute to this happening wherever they work, but policy makers should recognise that the ideal way to promote this would be through greater transition to caseload midwifery models. In these models of care a relationship is built between the woman and a known midwife who will be available to support the woman in those early hours after birth and importantly when she returns home. This is a particularly important point as the study identifies the need for ongoing support, particularly for women who are discharged from hospital partially breastfeeding, to enable them to build self-confidence and skill as they achieve full breastfeeding when home. This study provides further evidence to support the call for greater access to these models for all women.


**Abstract**

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The views of first time mothers completing an intervention to reduce postpartum weight retention: A qualitative evaluation of the mums OnLiNE study

Authors: van der Pligt P et al.

Summary: These authors employed descriptive qualitative research methods utilising semi-structured interview questions to explore new mothers’ views regarding their participation in the mums OnLiNE intervention, a pilot intervention program which aimed to limit postpartum weight retention and promote healthy diet and physical activity behaviours in new mothers. One-on-one interviews via telephone with 12 women were digitally recorded and transcribed verbatim. Data were analysed utilising thematic analysis for common, emerging themes. The main themes were: program usefulness, intervention components, walking, self-monitoring, barriers and challenges, and future recommendations. The women reported that they felt well supported being part of the program and their awareness of healthy eating increased. The most preferred activity was walking, as it was considered enjoyable and achievable, and some women reported that their incidental walking increased as a result of being part of the program. The main barriers to participation in the program were lack of time and motivation. The women valued the telephone support and found it the most helpful. The smartphone application for self-monitoring was utilised more often than the website. Encouraging group support and mother-baby exercise were suggested ideas for future programs.

Comment (MS): This interesting paper presents the results of a qualitative study designed to examine women’s experience of involvement in a 9-month program designed to enable women to adopt a healthy lifestyle and lose weight gained during pregnancy. The authors present some interesting statistics outlining how important it is to support women to lose the excess weight gained during pregnancy in order to reduce the risk of prolonged and increased weight gain with subsequent pregnancies. The counselling sessions with the dietitian were the most valued aspect of the program confirming the importance of providing connection and relationship where the woman can access support that is tailored to her individual needs. An encouraging finding was the increase in physical activity and women reported walking more. It is encouraging that women enjoyed the fact that the program information was accessible via their smart phone – further confirming the value in using this media to provide easily accessible information for women. Not surprisingly though, women found lack of time and need to focus on the baby to be the main demotivation in their efforts to engage fully with the program. This study highlights the important public health opportunities pregnancy and new motherhood presents. The work should begin during pregnancy where women could be encouraged to form social networks, for example in pregnancy centering groups, where they build relationships with their midwife and each other thus providing the social support that would be valuable in the postnatal period. We should be exploring the potential of studies like this and redesigning maternity care to encompass the wider public health issues that enable women to access appropriate information and support to make healthy lifestyle choices before and after the baby is born – building health literacy, confidence and social connection.

Reference: Midwifery 2018;56:23-8

You just need to leave the room when you breastfeed" Breastfeeding experiences among obese women in Sweden – A qualitative study

Authors: Claesson IM et al.

Summary: This exploratory Swedish study aimed to identify and describe obese (BMI >30 kg/m²) women’s experiences of breastfeeding. Semi-structured face-to-face interviews were undertaken with 11 obese women with breastfeeding experience 2-18 months after childbirth. The following three themes emerged: breastfeeding – a part of motherhood, the challenges of breastfeeding, and support for breastfeeding. The women commented that the body’s ability to produce milk fascinated them, that breast milk was the best way to feed the child and promote the attachment between mother and child, and they had antenatal hope for breastfeeding. They found that breastfeeding was a challenge with technical difficulties such as finding a good body position and helping the child to achieve an optimum grip of the nipple. Furthermore, the exposure of the body connected to public breastfeeding was also a challenge. With regard to support of breastfeeding, they described the need to be confirmed as an individual behind the obesity, rather than an individual with obesity, and to obtain enough professional breastfeeding support.

Comment (MS): As we are seeing greater numbers of women who begin pregnancy with a BMI >30 it is important that we identify how to best support “obese women” in their pregnancy, and how to prepare them for birthing and parenting. This paper provides the reader with an in depth exploration of the breastfeeding experiences of 11 women in Sweden who had a BMI >30 at the beginning of pregnancy. We already know that obese women are less likely to successfully breastfeed their babies, and this small study provides us with an insight into the challenges faced by women who did manage to breastfeed, although it is interesting that less than half of the women interviewed breastfed their baby for the recommended 6 months. The participants were recruited through the Weight Watchers association. This suggests they may have been more motivated towards adapting to a healthier lifestyle and indeed many of the participants had a BMI not greatly in excess of 30. Women in this study were motivated to breastfeed, but acknowledged the technical difficulties and embarrassment they experienced which linked to their size. The challenge to readers is to use the results from this study to provide the preparation support and encouragement new mothers need to establish and sustain breastfeeding. The results though in this case linked to women described as obese can be applied broadly. Women discussed their discomfort in breastfeeding in public places – work is still needed to campaign for better facilities and positive public attitudes to reduce the risk of cessation for this reason. Women in the study discussed the need for consistent holistic support. This is of course best provided by a known carer who provides care across the antenatal, birthing and postnatal period, integrating the care and working with others as care is transitioning to the child health nurse. Women in this study also said they wanted to be seen as the person they were, not behind a label of “obesity”. As we become more aligned to a risk averse model where labelling is common, it is important to apply the findings of this study and remember the power of relationship and the need to individualise care. The potential benefits of sustained breastfeeding extend beyond the immediate postnatal period and every effort should be made to support ALL women in their goal to feed their baby.


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EXPLORING THE SCIENCE OF THE SENSES™
IN HEALTHY BABY DEVELOPMENT

A strong body of foundational and emerging research suggests that multisensorial stimulation—or the concurrent stimulation of tactile, olfactory, auditory, and/or visual stimuli—benefits the social, emotional, cognitive, and physical development of babies.

A baby’s brain creates up to 1.8 million new synaptic connections per second between 2 months of gestation and two years after birth, and a baby’s experiences will determine which synapses will be preserved.1 Multisensorial stimulation—what a baby feels, smells, hears, and sees—helps promote the long-term survival of synaptic connections.1 Stimulation is essential early in development; within the first 3 years of life, there is rapid development of most of the brain’s neural pathways supporting communication, understanding, social development, and emotional well-being.2

Multisensorial Enrichment Increases Alertness in Preterm Infants6

Stimulating multiple senses sends signals to the brain that strengthen the neural processes for learning. Through consistent multisensorial experiences, research shows that babies gain healthy developmental benefits, such as reduced stress in healthy and preterm infants3,4 and better quality and quantity of sleep in healthy babies,5 as well as improved weight gain which led to earlier hospital discharge in preterm infants.6

Multisensorial stimulation—what a baby feels, smells, hears, and sees at every moment—helps promote the long-term survival of synaptic connections during brain development.1

Everyday experiences in a baby’s life can develop and stimulate his or her senses and provide parents an opportunity to nurture their baby’s ability to learn, think, love, and grow. A simple ritual of bath time and massage is an ideal opportunity to create a multisensorial experience. Bath time provides an opportunity for increased skin-to-skin contact (touch stimulation)7 and direct eye contact,8 as well as the introduction of new textures, sights, sounds, and smells that can stimulate a baby’s tactile, visual, olfactory, and auditory senses. The sense of smell, in particular, is directly linked to emotional memory,9 a mother’s scent can help soothe a crying baby,10 while a pleasant scent during bath time is shown to promote relaxation in both baby and parent.8

Bath time provides an ideal opportunity to create an enriched multisensorial experience.

Making Bath Time Part of a Routine Improves Sleep5

When bath time is part of an everyday ritual, the benefits have been shown to help generate a predictable and less stressful environment for the baby and parents.5

Although science has made advances in understanding the long-term benefits of multisensorial stimulation, there is more to be done to translate this research into everyday practice. By encouraging parents to view everyday rituals, such as bath time and massage, as opportunities for multisensorial stimulation, experiences can be created that can contribute to a lifetime of healthy development.
The midwife’s role in suicide prevention

Author: Holland C

Summary: This author reviewed the available literature between 2003 and 2017 on qualitative and quantitative research on maternal suicide. They identified three key themes: the characteristics associated with women dying from suicide, risk factors, and the attitudes and perceptions of midwives and effective screening. They concluded that in order to finally begin to reduce the rates of maternal death from suicide, every step must be taken to reflect on and improve midwifery practice around this issue.

Comment (MS): Suicide is acknowledged to be a leading cause of maternal death in the UK, with no reduction in incidence in recent years. This paper seeks to provide the reader with a review of the literature to examine what role midwives could play in prevention. Three main themes were identified by the review and are discussed in the context of maternity service provision in the UK. This paper is relevant to Australian midwives too as there is increasing awareness in Australia of the pregnancy-related risk of suicide. The women who do take their own lives often have complex social and medical histories, so it is important to acknowledge the need to work collaboratively to ensure women at risk are identified and supported. Screening is thought to be an important tool, but the literature review states not enough is known around how to effectively screen women for mental illness. In addition, a study conducted in Australia proposed that midwives felt apprehensive and ill-equipped in assessing mental health status and suicide risk. Midwives are only going to be able to make an impact if their education needs are met around awareness raising and approaches to integrated care packages. The review highlights the impact cuts in mental health services have had in the UK making it more probable that women identified as being at risk will fall through the cracks in the system. The review discusses the benefits of continuity of midwifery models where women have been identified as more likely to engage with mental health services. Clearly the review provides some helpful insight into changes that are needed at an organisational level to begin to address this problem and enable midwives to support “at-risk” women. The maternity care system needs to be revised to provide integrated individualised care for all women where the woman has the opportunity to develop a relationship with a key carer (usually the midwife). The review suggests that all women identified as “at risk” should be in a caseload model, but I would go further and say all women should by default be offered caseload care, as it is more likely those who are “at risk” will be identified through that model of care. Secondly, all maternity carers should have access to high-quality interdisciplinary education to increase knowledge and confidence in identifying and caring for women at risk.


A woman’s hand and a lion’s heart: Skills and attributes for rural midwifery practice in New Zealand and Scotland

Authors: Gilkison A et al.

Summary: The range of skills, qualities and professional expertise needed for remote and rural midwifery practice in New Zealand and Scotland were investigated via a questionnaire circulated to all midwives working within these environments; 222 midwives participated in this online study, 145 from New Zealand and 77 from Scotland. In a follow-up secure online discussion forum, midwives shared their views about their specific skills, qualities and challenges, and how rural midwifery can be sustained. Qualitative descriptive thematic analysis revealed that underpinning rural midwifery practice is the essence of ‘fortitude’, having the determination, resilience, and resourcefulness to deal with the many challenges faced in everyday practice and to safeguard midwifery care for women within their communities.

Comment (MS): Australia has seen the closure of rural and remote maternity services over the last two decades but more recently communities are lobbying for restoration of services. There is a policy commitment to identify ways in which women in rural and remote communities can access safe maternity services with an increasing awareness of the need to “re think” the way we provide services for these women. Many rural communities in Australia have reconfigured the workforce and introduced caseload midwifery models. Key to the success of these models is a competent resilient midwifery workforce. This qualitative study surveyed and interviewed rural midwives in Scotland and New Zealand, where a caseload approach to care is the norm, to explore the range of skills, qualities and professional expertise needed for remote and rural midwifery practice. The results from the study provide valuable information for policy makers, education providers, midwives and managers in Australia. The strength, courage and experience of the rural midwives is clearly evident in this paper. Thematic analysis of the qualitative data from both countries reveals that underpinning rural midwifery practice is the essence of ‘fortitude’, which includes having the determination, resilience, and resourcefulness to deal with the many challenges faced in everyday practice and to safeguard midwifery care for women within their rural communities. Importantly, the midwives also spoke of the need for self-care, recognising that “to survive and thrive in rural midwifery practice they needed to be self-dependent, self-reliant, self-supporting and have a healthy work-life balance”. In order to develop these skills it is important to enable midwifery students to undertake clinical practice alongside these experienced midwives within rural communities. Education providers should, as a priority, identify ways in which this can be addressed within current and future programs in Australia.

Reference: Midwifery 2018;58:109-16

Anxiety, depression and relationship satisfaction in the pregnancy following stillbirth and after the birth of a live-born baby: a prospective study

Authors: Gravensteen IK et al.

Summary: This study used data from the Norwegian Mother and Child Cohort Study, a population-based pregnancy cohort, to identify the prevalence of anxiety and depression and satisfaction with partner relationships during pregnancy and up to 3 years after the birth of a live-born baby following stillbirth. Data were collected from 901 pregnant women; 174 pregnant after a stillbirth, 362 pregnant after a live birth and 365 previously nulliparous. In the third trimester of pregnancy and 6, 18 and 36 months postpartum, relationship satisfaction was measured with the Relationship Satisfaction Scale and anxiety and depression were measured using the short-form subscales of the Hopkins Symptoms Checklist. The prevalence of anxiety and depression were higher in women pregnant after stillbirth (22.5% and 19.7%) compared with women with a previous live birth (aORs 5.47; 95% CI 2.90-10.32 and 1.91; 95% CI 1.11-3.27, respectively) and previously nulliparous women (aOR 4.97; 95% CI 2.68-9.24 and 1.91; 95% CI 1.08-3.36). There was no association observed between anxiety and depression and gestational weeks 30 to 50 weeks or inter-pregnancy interval <12 months. While anxiety and depression decreased 6-18 months following the birth of a live-born baby, they had increased at 36 months postpartum. There was no difference in relationship satisfaction between the groups.

Comment (KB): There is a strong desire for women who have experienced a still birth to become pregnant again as soon as possible and about 50% tend to embark on a new pregnancy with 12 months of experiencing a stillbirth. It is also suggested that for women who have experienced a previous stillbirth they will be more vulnerable to anxiety, depression and post-traumatic stress when they become pregnant again. This current study used data from the Cohort Study and records from the Medical Birth Registry of Norway to explore this suggestion. Participants were recruited from all over Norway and identified 197 women in the Norwegian Mother and Child cohort who had experienced a stillbirth in a previous pregnancy. The reference groups in the study included 394 women with a previous live birth and 394 nulliparous women. Women with a high BMI and low educational level were more prevalent in the previous stillbirth group compared with both reference groups. During the third trimester of pregnancy women with a previous stillbirth experienced higher levels of anxiety and depression compared with women with previous live births and nulliparous women. The prevalence of anxiety and depression decreased significantly from the first assessment to 6 months postpartum among the women with a previous stillbirth. By 6 and 18 months postpartum, respectively, the prevalence of depression and anxiety was not significantly different between groups. However, from 6 to 36 months postpartum, the prevalence of anxiety and depression increased significantly in the stillbirth group when compared with women with a previous live birth, but not when compared with previous nulliparous women. Clearly the results from this study confirm that anxiety and depression for women who have experienced a stillbirth is still prevalent for some in their next pregnancy and perhaps this is not to be unexpected as many women will be anxious about a subsequent pregnancy remembering what had occurred in their previous pregnancy. However, the levels of depression and anxiety among this group had declined and were comparable to the reference groups by 6 to 18 months postpartum. Such findings clearly indicate that midwives should screen carefully for symptoms of depression and anxiety among pregnant women following a stillbirth and provide individualised support and reassurance as required.


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Midwifery students' understanding and knowledge of normal birth before 'delivery' of curriculum

Authors: Davison C et al.

Summary: This study involving 20 undergraduate and 18 postgraduate midwifery students at a tertiary University in Western Australia used a qualitative descriptive approach in conjunction with an anonymous questionnaire to generate new knowledge that describes and explains the views and understanding around midwifery and normal birth of newly-enrolled midwifery students at the beginning of their midwifery education.

Comment (KB): The aim of this qualitative descriptive study was to review new midwifery students’ perceptions and attitudes surrounding the role of the midwife, normal birth and breastfeeding. Included in the study was a comparison between undergraduate and postgraduate midwifery students. Several themes arose from the survey data and whilst most of themes were the same for the undergraduate and postgraduate students, there were some differences between the two groups. For instance, postgraduate students who were registered nurses used more medicalised language than the undergraduate students; this finding should not be unexpected as many postgraduate students had been working within a medicalised model of care prior to beginning their midwifery training. All of the students believed women would need pain relief to cope with labour and birth. When asked why they wanted to be a midwife, the undergraduate students’ responses were different to the postgraduate responses. The undergraduate midwives’ responses had a strong focus on helping and supporting women whereas the postgraduate students appeared to focus on their own needs citing it as a ‘rewarding career’ and an opportunity to be involved in something ‘happier than nursing’. Overall the students in this study did appear to recognise that birth was about the woman and her experience. However, again there were some differences in the responses between the two groups, which seem to clearly reflect the impact that experiences gained from nursing can have on student’s ideas around birth. Both groups of students demonstrated a limited understanding of the role and scope of the midwife, although experiences gained from nursing can have on student’s ideas around birth. Both groups of students who were pre-treated with 200 mg oral mifepristone 24-48 hours prior to admission. Upon admission, the women in the pre-treatment group followed the same treatment regime as the women who did not receive any pre-treatment. A total of 147 women were included in the study, 63 in the MT group and 84 in the NMT group. 57 women were induced with misoprostol, 27 were induced with oxytocin. There was a significant difference in the median duration of labour in the NMT and MT groups (4.0 hours vs 2.5 hours). There was also a difference in the duration of admission and labour (2 days in the NMT group and 1 day in the MT group). In both groups, 60 minutes was the time allowed for the spontaneous delivery of the placenta. 16 women in the NMT group and 10 in the MT group did not spontaneously deliver the placenta. The results from this particular study demonstrate that women who received the pre-treatment dose of mifepristone had a 38% reduction in the duration of their labour, resulting in a reduced admission time of 1 day. There was also a difference in analgesia use between the two cohorts with the rate of epidural use in the NMT group 21% as opposed to 2% in the MT cohort. While this paper presents some interesting findings in terms of shorter labours for women in the mifepristone group, it would have been interesting to evaluate the women’s experiences in both groups, especially in the women who received the pre-treatment dose of oral mifepristone 24-48 hours prior to admission.

Reference: Midwifery 2018;58:77-82

Abstract

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Midwifery Research Review

Comparison of induction of labour regimes for termination of pregnancy, with and without mifepristone, from 20 to 41 weeks gestation

Authors: Fyfe R and Murray H

Summary: The efficacy of mifepristone for induction of labour was investigated in this retrospective cohort study involving 147 women who underwent a medical termination of a singleton pregnancy between 20 and 41 weeks’ gestation for either a fetal abnormality or fetal death in utero between 1 January, 2009 and 1 January, 2014. Of the 147 women, 63 received mifepristone pre-treatment (MT) prior to being induced and 84 did not (NMT). A 38% reduction in the median duration of labour was observed in the group of women induced after mifepristone pre-treatment (2.5 hours in MT group vs 4.0 hours in the NMT group; p = 0.001). Women in the MT group exhibited a 50% reduction in the number of hours in labour (2.5 hours in MT group vs 4.0 hours in the NMT group; p = 0.001). Women in the MT group exhibited a 50% reduction in the number of hours in labour (2.5 hours in MT group vs 4.0 hours in the NMT group; p = 0.001). Women in the MT group exhibited a 50% reduction in the number of hours in labour (2.5 hours in MT group vs 4.0 hours in the NMT group; p = 0.001).

Comment (KB): Approximately 2% of terminations are performed after 20 weeks’ gestation, with most being performed for a fetal abnormality. The aim of this study was to investigate the efficacy of mifepristone for induction of labour at 20-41 weeks’ gestation. The study compared the length of labour in women with and without mifepristone pre-treatment. The first group of women were induced without the mifepristone pre-treatment regime and the second group were pre-treated with 200 mg oral mifepristone 24-48 hours prior to admission. Upon admission, the women in the pre-treatment group followed the same treatment regime as the women who did not receive any pre-treatment. A total of 147 women were included in the study, 63 in the MT group and 84 in the NMT group. 57 women were induced with misoprostol, 27 were induced with oxytocin. There was a significant difference in the median duration of labour in the NMT and MT groups (4.0 hours vs 2.5 hours). There was also a difference in the duration of admission and labour (2 days in the NMT group and 1 day in the MT group). In both groups, 60 minutes was the time allowed for the spontaneous delivery of the placenta. 16 women in the NMT group and 10 in the MT group did not spontaneously deliver the placenta. The results from this particular study demonstrate that woman who received the pre-treatment dose of mifepristone had a 38% reduction in the duration of their labour, resulting in a reduced admission time of 1 day. There was also a difference in analgesia use between the two cohorts with the rate of epidural use in the NMT group 21% as opposed to 2% in the MT cohort. While this paper presents some interesting findings in terms of shorter labours for women in the mifepristone group, it would have been interesting to evaluate the women’s experiences in both groups, especially in the women who received the pre-treatment dose of oral mifepristone 24-48 hours prior to admission.


Abstract

Independent commentary by Associate Professors Mary Sidebotham & Kathleen Baird

Associate Professor Mary Sidebotham is a registered midwife and is currently employed by Griffith University as the Program Director of Primary Maternity Care degree programs. She is a visiting Associate Professor at the Gold Coast University Hospital Queensland and a member of the research ethics committee. Mary is the Midwifery Editor of the Nurse Education in Practice Journal. She contributes to maintaining professional standards through her work as a midwifery educational program assessor for the Australian Midwifery Accreditation Council, an approved panel member for the NMBA and as an assessor for the Queensland Civil and Administrative Tribunal.

Associate Professor Kathleen Baird is a Midwifery Lecturer within the School of Nursing and Midwifery at Griffith University, Queensland, Australia and is the Director of Nursing and Midwifery Education, Women’s and Newborn Services, Gold Coast University Hospital. She is also joint director of the newly formed Centre for Women’s and Newborn Research, Gold Coast University Hospital and Menzies Health Institute Queensland. Kathleen is an educational program assessor for the Australian Midwifery Accreditation Council, and holds an appointment as a Senior Research Fellow with the University of the West of England.

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Paternal postnatal depression in Ireland: Prevalence and associated factors

Authors: Philpott LF and Corcoran P

Summary: This Irish cross-sectional study investigated the prevalence of paternal postnatal depression (PPND) and examined its associations with a range of demographic and clinical factors. Using the Edinburgh Postnatal Depression Scale, data was collected from 100 fathers whose partner had given birth to an infant in the previous 12 months. When the Edinburgh Postnatal Depression Scale cut off score was 12 or above the prevalence of PPND was 12% and when the cut off score was reduced to 9 or above the prevalence was 28%. The following factors were identified as increasing the risk of PPND: having an infant with sleep problems, a previous history of depression, a lack of social support, poor economic circumstances, not having paternity leave and not being married.

Comment (KB): PPND is not commonly acknowledged or well researched and although some factors have been identified in contributing to PPND, the actual pathway of the causality is not always obvious. Therefore, this cross-sectional study involving 100 fathers is welcomed. This particular study examined associations with a range of demographic and clinical factors. The Edinburgh Postnatal Depression Scale was the only scale used in the study, using a cut off score of 12 or above and 9 or above to assess for PPND. PPND was most prevalent in the first 6 months postpartum compared to the second 6 months suggesting that some fathers required extra time to adjust to the role of being a father. Several factors were identified as having an association with PPND, including having a baby who was either pre-term or post-dates, caring for a baby with sleeping difficulties, living in rented accommodation, or experiencing poor economic circumstances. Certainly, fathers who self-reported that they were struggling to survive financially had a statistically significant risk of developing PPND. Interestingly, fathers who did not receive paternal leave also had a high risk of developing PPND with a prevalence rate of 19.4% compared to 4.2% for fathers who had paternal leave. It also appears that fathers who had an infant with sleeping difficulties were at a risk of developing PPND. In comparison, fathers whose babies was not born pre-term or post-dates was less likely to experience PPND. The findings of this study clearly outline some risk factors for PPND, which can be divided into the category of father relationship, infant and environmental factors. Of course, it must be realised that the birth of a baby may also heighten and emphasise certain conditions in a person’s life such as poor housing conditions and unemployment. Regardless, this study highlights that as midwives we should also consider the mental health of fathers as well as mothers during the postnatal period. Poor paternal mental health has the potential to have a profound impact on the mother’s mental health and wellbeing as she attempts to adjust to her new role as a mother with limited support from a partner who is struggling to adapt to his role as a father.

Reference: Midwifery 2018;56:121-7

Midwives’ personal use of complementary and alternative medicine (CAM) influences their recommendations to women experiencing a post-date pregnancy

Authors: Mollart L et al.

Summary/Comment (KB): Numerous studies have documented the increasing growth of health consumers using complementary and alternative medicine (CAM). Therefore, it should not be surprising that women are increasingly taking this approach when experiencing a post-date pregnancy. This study by Mollart and colleagues was conducted to address a gap in the literature pertaining to Australian midwives’ personal use of CAM and what, if any, CAM options Australian midwives are recommending to pregnant women in relation to a post-date pregnancy. The data was collected by survey with a total of 571 midwives completing the survey. More than half of the respondents indicated they provided care in all spheres of midwifery practice. Most of the participants, 88.4% (n = 505) recommended self-help and CAM therapies to a woman experiencing a post-date pregnancy. The top five self-help strategies recommended by midwives included sexual intercourse (83.2%), increase in exercise such as walking and swimming (82.3%), nipple stimulation (79%), followed by eating spicy foods (16.8%) and lastly castor oil (5.8%). Other CAM strategies included acupuncture (65.7%), acupressure (58.1%), raspberry leaf (52.5%), massage (38.9%), hypnosis/calmbirthing/hypnobirthing (35.7%). 55.2% of the midwifery participants would refer the woman to a CAM practitioner with an acupuncturist proving to be the most popular CAM practitioner at 89.8%, followed by calmbirthing/hypnotherapist (54%), massage therapist (44.4%), reflexologist (35.2%) and lastly naturopath (33%). In terms of their own personal use, 80.4% of midwives surveyed had used CAM therapies for their own personal use with many using an array of therapies. Nearly half of all the respondents had used CAM therapies for their own pregnancy. Predictably, midwives who had personally used CAM therapies were more likely to recommend self-help and CAM strategies. Midwives who recommended the use of CAM therapies were of a younger cohort and had less years qualified as a midwife, compared with midwives who were not likely to recommend self-help or CAM therapies to women. However, a limitation of this particular study, which is acknowledged by the research team, is the possibility that only midwives interested in CAM may have responded to the survey. Nonetheless, as it is becoming much more common place for women to use CAM therapies during pregnancy, it is important that midwives have the knowledge and confidence to discuss not only the various options that are available but also the safety of using the therapies during pregnancy. Therefore, midwifery education programs and professional education study days should consider incorporating CAM content, which will provide midwives with the knowledge and the evidence base to be able to communicate with pregnant women in an informed way.


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