AIMS For a better birth...

Research Roundup

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Birth Companions and Postnatal Depression

Researchers in South Africa looked at the effects of having a birth companion in labour. Coronation Hospital in Johannesburg mostly looks after women who are poor, and Asian or of mixed race. There are not enough "nurses" (sic) to provide continuous support to labouring women. Birth companions (unpaid) were recruited by advertisements in local community centres. Women who were expecting their first child and had no companion, and were already in labour, were asked to join a trial where they would be randomly allocated to have a companion or not. Clinical results were reported in another paper, but this one looks at depression as an outcome.

Around 80% of the women were unmarried and over 60% had a monthly income of less than $400.

When they were assessed the day after giving birth, mothers who had the doula (birth companion) and those who did not, had similar scores for self-esteem. But six weeks later those allocated a companion had much higher self-esteem than controls. In fact controls actually got worse during their first six weeks of motherhood - their self esteem fell.

Anxiety at 6 weeks was lower in those who had a companion than in those who did not.

Depression was also lower in mothers who had a birth companion in labour. Not one of the supported women became severely depressed, whereas 22% of the unsupported women got a high depression score, and 37% got a medium depression score compared with only 11% of supported women.

The authors concluded: "Companionship in labour had a striking effect on the woman's feelings of self-confidence. If feelings of competence that are initiated during labour, a time of intense emotional impressionability, are of importance to a woman's continuing sense of competence as a mother, then this finding is of considerable importance... We need to accept... that labor is a time of unique sensitivity to environmental factors and that events and interactions during labor may have far-reaching and powerful

psychological consequences."

AIMS Comment

Although this study was published several years ago (I had somehow missed it) it is useful to know about. It adds to the literature - which I think someone should collect - showing how hospital maternity care introduced a number of changes which have since been shown to be damaging to women and babies. When they were at home, almost all women would naturally have had a companion- mother, sister, or the woman next door. Just as routine shaves, routine enemas, routine episiotomies, etc. have all been shown to do more harm than good, so routine separation of women from support is also shown to be harmful, and many studies of doulas have shown benefits. Please note that these were not companions the women chose - they simply got what they were allocated, and we do not know what difference a companion of their choice, or a trained doula might make.

One important aspect of this study is that it is the women who are already disadvantaged economically and psychologically who are unlikely to have a labour companion. Despite their low incomes, over 75% of the partners were employed, and as the study was carried out only in daytime, they probably could not afford to take time off work to be with women. It is those mothers, facing greater difficulties in rearing children, who will most need their self-esteem and to avoid extra causes of depression.

Finally, recruitment to the study would be unacceptable by today's ethical standards, and certainly according to the joint AIMS/NCT Charter. Women were not asked to join until they were in labour and the study itself shows that around 80% of them were in pain at the time. The women who were allocated to the control group, having had their hopes raised by agreeing to be randomised, may well have been disappointed and this might adversely have affected their outcome. As the study was funded by the South African Medical Research Council and the Association for Childbirth and Parenthood, we hope their ethical standards have improved by now.

Reference

- Wolman W et al, Postpartum depression and companionship in the clinical birth environment: A randomized controlled study, Am J Ob Gyn, 1993; 168: 1388-1393

Another Doula Study

The latest doula study comes from a hospital in Botswana. In this paper, unlike other published studies, female relatives were used as the mother's companion in labour for women expecting their first child. They were compared to a random control group who had the "usual" care who had no such companion and were cared for by staff looking after an average of four women each in labour rooms which have 12 beds with plastic curtains in between and little privacy.

Those with a supporting relative were more likely to have a vaginal delivery (91% v 71%) less oxytocin

(13% v 30%) fewer amniotomies (30% vv 54%), fewer vaccuum extractions (4% v 16%) less analgesia (53% v 73%), and fewer caesareans (6% v 13%).

All these differences were statistically significant.

AIMS Comment

What this hospital - a major referral centre - was doing, was reverting to what is traditional birthing practice in Botswana, where women gave birth usually at their parents' home and were supported by a traditional birth attendant and a female relative. Like all the other studies, it shows measurable important benefits of "allowing" women to have a companion - or rather reveals the past pattern of damage caused by the "progress" of modern medicine. Like the Mexican study reviewed in our Autumn 1998 journal, it also reveals how much worse conditions can be for women giving birth in Third World countries, and how much more important doulas are.

This study, too, raises ethical questions. It was conducted between October 1994 and January 1995. It has taken more than 4 years to publication. There are now so many trials showing benefits of doulas - whether trained, untrained, relatives or not, that we suggest the point has been reached when it would be unethical to do another trial, even in the Third World, or perhaps especially in the Third World, in which controls are allocated to a "no intervention" group. Even when this research began, at least 8 studies had already been published showing benefits, although admittedly no-one had used female relatives.

One thing is certain. Hospitals here who deny or prevent women's access to labour companions might well find themselves subject to legal action, or at least the charge that they are not practising evidence-based medicine. AIMS still get complaints from women especially in Wales - that midwives are refusing to call husbands when women are asking for them. Our advice is *never have a baby in a hospital without taking a mobile phone!* even if you have to borrow one.

Reference

- Madi B. et al, Effects of female relative support in labor: a randomized controlled trial, Birth, 1999; 26: 4-8

Infection Caused by Internal Examinations

A group of obstetricians in Ohio has looked at bacteria present around the cervix before and after vaginal examinations.

35 women in labour (25 of them with ruptured membranes) had a speculum examination and at the same time a sample of fluid was taken to check bacteria. After this the cervix was examined by a doctor wearing a sterile glove. Then they had a second speculum examination and another sample was taken.

The first sample showed an average of 2.8 different kinds of organisms, the second showed 4.4. In 20 of

the women there was an increase in quantity of at least one of the bacteria;, and women with ruptured membranes were more likely to have such an increase.

Although this was not a randomised study, the doctors did do two speculum examinations*without* a digital examination in between on 5 women, and the number of organisms did not increase in them.

As the authors point out "An immediate effect of digital examination of the cervix is the introduction of vaginal organisms into the cervix."

AIMS Comment

Yet another study showing the relationship between VEs in labour and increased infection risk.

The women were apparently recruited to the study after they entered the hospital in labour. By the standards of the AIMS/NCT Charter for Ethical Research in Maternity Care, they should have been fully informed of the study during pregnancy in order to give valid consent under the stress of labour or ruptured membranes.

Reference

- Imseis H, et al, The microbiologic effect of digital cervical examination, Am J Ob Gyn, 1999; 180: 578-80

Avoiding Rupture of the Anal Sphincter

A joint study from Sweden and Finland raises questions about how damage to the anal sphincter could be avoided. If rupture of the sphincter occurs during delivery the woman is often left with permanent fecal incontinence, as well as other problems.

Researchers discovered that for comparable low risk patients, the risk of anal sphincter damage was 13 times higher in Malmo in Sweden than in Turku in Finland. So they compared the way the head is delivered. In Sweden the baby's head is allowed to pass through naturally, or occasionally a certain degree of downward pressure on the baby's head is used and a hand is held against the perineum. In Finland the midwife presses the baby's head with her left hand to control the speed of crowning. At the same time the thumb and index finger of the right hand support the perineum while the middle finger is used to grip the baby's chin. The woman is asked to stop pushing while the midwife slowly helps the baby out. When most of the head is out, the perineal ring is pushed under the baby's chin.

AIMS Comment

The authors conclude that the huge difference in outcome may be due to the difference in support given to the perineum and the baby's head when crowning. Clearly this is not the end of the story. What we need is a good library of film on different styles of managing labour and delivery - for different areas, and

at different times. As we saw from the TV films of midwifery training in Hertfordshire, the movie camera can tell you a lot more about what goes on than written descriptions.

Reference

- Pirhonen J et al, *Frequency of anal sphincter rupture at delivery in Sweden and Finland - result of difference in manual help to the baby's head*, Acta Obstet Gynaecol Scand 1998; 974-77