

# CHAPTER 1: THE CONTEXT OF CARE FOR PREGNANT WOMEN

**H**ow care is provided to childbearing women and by whom varies considerably between countries, and between health sectors within countries.

☺ **CONTINUITY OF CAREGIVERS FOR CARE DURING PREGNANCY AND CHILDBIRTH:** reduced: hospital admission; use of pain relief in labour; resuscitation in newborns; and increased satisfaction with their care. (Hodnett ED) CD000062

**BACKGROUND:** Care during pregnancy, childbirth and the postnatal period is often provided by multiple caregivers, many of whom work only in the antenatal clinic, labour ward or postnatal unit. However, continuity of care is provided by the same caregiver or a small group from pregnancy through the postnatal period.

**OBJECTIVES:** To assess continuity of care during pregnancy and childbirth and the puerperium with usual care by multiple caregivers.

**METHODS:** Standard PCG methods (see page xvii). Search date: April 2000.

**MAIN RESULTS:** Two studies, involving 1815 women, were included. Both trials compared continuity of care by midwives with non-continuity of care by a combination of physicians and midwives. The trials were of good quality. Compared to usual care, women who had continuity of care from a team of midwives were less likely to be admitted to hospital antenatally (odds ratio (OR) 0.79, 95% confidence interval (CI) 0.64 to 0.97) and more likely to attend antenatal education programmes (OR 0.58, 95% CI 0.41 to 0.81). They were also less likely to have drugs for pain relief during labour (OR 0.53, 95% CI 0.44 to 0.64) and their newborns were less likely

---

*A Cochrane Pocketbook: Pregnancy and Childbirth* G.J. Hofmeyr et al.

Copyright © 2008, Z. Alfiervic, C. A. Crowther, L. Duley, A. M. Gulmezoglu, G. ML. Gyte, E. D. Hodnett, G. J. Hofmeyr, J. P. Neilson

to require resuscitation (OR 0.66, 95% CI 0.52 to 0.83). No differences were detected in Apgar scores, low birthweight and stillbirths or neonatal deaths. While they were less likely to have an episiotomy (OR 0.75, 95% CI 0.60 to 0.94), women receiving continuity of care were more likely to have either a vaginal or perineal tear (OR 1.28, 95% CI 1.05 to 1.56). They were more likely to be pleased with their antenatal, intrapartum and postnatal care.

**AUTHOR'S CONCLUSIONS: Studies of continuity of care show beneficial effects. It is not clear whether these are due to greater continuity of care or to midwifery care.**

**GIVING WOMEN THEIR OWN CASE NOTES TO CARRY DURING PREGNANCY:** increased women's sense of control; but also increased operative births. (Brown HC, Smith HJ) CD002856

**BACKGROUND:** In many countries women are given their own case notes to carry during pregnancy so as to increase their sense of control and satisfaction with their care.

**OBJECTIVES:** To evaluate the effects of giving women their own case notes to carry during pregnancy.

**METHODS:** Standard PCG methods (see page xvii). Search date: June 2007.

**MAIN RESULTS:** Three trials were included (n = 675 women). Women carrying their own notes were more likely to feel in control (relative risk (RR) 1.56, 95% confidence interval (CI) 1.18 to 2.06). Women's satisfaction: one trial reported more women in the case notes group (66/95) were satisfied with their care than the control group (58/102) (RR 1.22, 95% CI 0.99 to 1.52); two trials reported no difference in women's satisfaction (one trial provided no data and one trial used a 17 point satisfaction scale). More women in the case notes group wanted to carry their own notes in a subsequent pregnancy (RR 1.79, 95% CI 1.43 to 2.24). Overall, the pooled estimate of the two trials (n = 347) that reported on the risk of notes lost or left at home was not significant (RR 0.38, 95% CI 0.04 to 3.84). There was no difference for health related behaviours (cigarette smoking and breastfeeding), analgesia needs during labour, miscarriage, stillbirth and neonatal deaths. More women in the case notes group had operative deliveries (RR 1.83, 95% CI 1.08 to 3.12).

**AUTHORS' CONCLUSIONS: The three trials are small, and not all of them reported on all outcomes. The results suggest that there are**

**both potential benefits (increased maternal control and satisfaction during pregnancy, increased availability of antenatal records during hospital attendance) and harms (more operative deliveries). Importantly, all of the trials report that more women in the case notes group would prefer to hold their antenatal records in another pregnancy. There is insufficient evidence on health related behaviours (smoking and breastfeeding) and clinical outcomes. It is important to emphasise that this review shows a lack of evidence of benefit rather than evidence of no benefit.**

**MIDWIFERY-LED VERSUS OTHER MODELS OF CARE DELIVERY FOR CHILDBEARING WOMEN:** (Hatem M, Hodnett ED, Devane D, Fraser WD, Sandall J, Soltani H) Protocol [see page xviii] CD004667

**ABRIDGED BACKGROUND:** In many parts of the world, midwives are the primary providers of care for childbearing women. There are, however, considerable variations in the organization of midwifery services and in the education and role of midwives. Furthermore in some countries, e.g. in North America, medical doctors are the primary care providers for the vast majority of childbearing women, while in other countries, e.g. Australia, the UK, and Ireland, various combinations of midwifery-led, medical doctor-led, and shared care models are available, and childbearing women may be faced with many different options and conflicting advice as to which option is best for them.

**OBJECTIVES:** The primary objective of this review is to compare midwifery-led models of care with other models of care for childbearing women and their infants.

**CRITICAL INCIDENT AUDIT AND FEEDBACK TO IMPROVE PERINATAL AND MATERNAL MORTALITY AND MORBIDITY:** found no randomised trials. (Pattinson RC, Say L, Makin JD, Bastos MH) CD002961

**BACKGROUND:** Audit and feedback of critical incidents is an established part of obstetric practice. However, the effect on perinatal and maternal mortality is unclear. The potential harmful effects and costs are unknown.

**OBJECTIVES:** Is critical incident audit and feedback effective in reducing the perinatal mortality rate, the maternal mortality ratio and severe neonatal and maternal morbidity?

**METHODS:** Standard PCG methods (see page xvii). Search date: January 2005.

**MAIN RESULTS:** None.

**AUTHORS' CONCLUSIONS:** The necessity of recording the number and cause of deaths is not in question. Mortality rates are essential in identifying problems within the healthcare system. Maternal and perinatal death reviews should continue to be held, until further information is available. The evidence from serial data clearly suggests more benefit than harm. Feedback is essential in any audit system. The most effective mechanisms for this are unknown, but it must be directed at the relevant people.

**TRADITIONAL BIRTH ATTENDANT TRAINING FOR IMPROVING HEALTH BEHAVIOURS AND PREGNANCY OUTCOMES:** reduced perinatal complications; more research needed. (Sibley LM, Sipe TA, Brown CM, Diallo MM, McNatt K, Habarta N) CD005460 (in RHL 11)

**BACKGROUND:** Between the 1970s and 1990s, the World Health Organization promoted traditional birth attendant (TBA) training as one strategy to reduce maternal and neonatal mortality. To date, evidence in support of TBA training remains limited and conflicting.

**OBJECTIVES:** To assess effects of TBA training on health behaviours and pregnancy outcomes.

**METHODS:** Standard PCG methods (see page xvii). Search date: June 2006.

**MAIN RESULTS:** Four studies, involving over 2000 TBAs and nearly 27 000 women, are included. One cluster-randomized trial found significantly lower rates in the intervention group regarding stillbirths (adjusted OR 0.69, 95% confidence interval (CI) 0.57 to 0.83,  $P < 0.001$ ), perinatal death rate (adjusted OR 0.70, 95% CI 0.59 to 0.83,  $P < 0.001$ ) and neonatal death rate (adjusted OR 0.71, 95% CI 0.61 to 0.82,  $P < 0.001$ ). Maternal death rate was lower but not significant (adjusted OR 0.74, 95% CI 0.45 to 1.22,  $P = 0.24$ ) while referral rates were significantly higher (adjusted OR 1.50, 95% CI 1.18 to 1.90,  $P < 0.001$ ). A controlled before/after study among women who were referred to a health service found perinatal deaths decreased in both intervention and control groups with no significant difference between groups (OR 1.02, 95% CI 0.59 to 1.76,  $P = 0.95$ ). Similarly, the mean number of monthly referrals did not differ between groups ( $P = 0.321$ ). One RCT

found a significant difference in advice about introduction of complementary foods (OR 2.07, 95% CI 1.10 to 3.90,  $P = 0.02$ ) but no significant difference for immediate feeding of colostrum (OR 1.37, 95% CI 0.62 to 3.03,  $P = 0.44$ ). Another RCT found no significant differences in frequency of postpartum haemorrhage (OR 0.94, 95% CI 0.76 to 1.17,  $P = 0.60$ ) among women cared for by trained versus TBAs.

**AUTHORS' CONCLUSIONS:** The potential of TBA training to reduce peri-neonatal mortality is promising when combined with improved health services. However, the number of studies meeting the inclusion criteria is insufficient to provide the evidence base needed to establish training effectiveness.

**MATERNITY WAITING FACILITIES FOR IMPROVING MATERNAL AND NEONATAL OUTCOME IN LOW-RESOURCE COUNTRIES:**

(van Lonkhuijzen L, Stekelenburg J, van Roosmalen J) Protocol [see page xviii] CD006759

**ABRIDGED BACKGROUND:** Low utilisation of maternal health services is mainly a result of barriers to access, and leads to high maternal and perinatal mortality and morbidity. Differences in utilisation figures between high- and low-income countries are enormous. Access to maternity health services is a key indicator for maternal mortality. Therefore, reaching a health facility, which can provide emergency obstetric care, is the best tool for reducing maternal mortality, and will also lead to a significant reduction of perinatal morbidity and mortality. Since the 1960s, maternity waiting homes have been advocated to bridge the geographical gap and the difference in care received by women living in remote areas compared to the women living in urban areas. The maternity waiting home could be anything from a simple hut with a latrine where women would care for themselves, to a fully catered for building. Waiting homes may be provided by the health authorities or by the local community. As one component of a comprehensive package of essential obstetric services, maternity waiting homes may offer a cheaper and more effective way to bring women close to obstetric care, as compared to interventions that aim to bring women to a hospital only at the time of delivery or complication.

**OBJECTIVES:** To assess, using the best available evidence, the effects of a maternity waiting facility on maternal and perinatal health.

