Maternal and Child Health Nurse interviews: Report on Findings

P R I S M

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Acknowledgements

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PRISM Research Team members are Professor Judith Lumley, Dr Rhonda Small, Dr Stephanie Brown, Ms Creina Mitchell and Ms Lyn Watson from the Centre for the Study of Mothers' and Children's Health, and Natasha Davidson, Public Health Trainee for the Victorian Public Health Training Scheme.

Introduction

In 1997, the Centre for the Study of Mothers' and Children's Health initiated the Program of Resources, Information and Support for Mothers (PRISM). PRISM aims to improve the physical and emotional health of mothers. It is a randomised trial, in eight intervention and eight comparison local government areas, of primary care and community based strategies designed to mobilise appropriate community support for mothers and children with a view to strengthening local communities and building capacity to address social and health issues. It is an intersectorial collaborative effort amongst universities, local government areas, maternal and child health teams, local GPs and communities.

The maternal and child health nurses (MCHNs) have played a key role in PRISM while distributing PRISM kits to women, addressing their physical and emotional health issues and facilitating befriending activities.

MCHN interviews

Telephone interviews with MCHNs conducted at two time points (Dec-Jan 1999/2000 and Sept-Dec 2001) have formed part of the process evaluation in PRISM.

The main aim of the MCHN interviews was to collect data from all MCHNs about their involvement in the implementation of key PRISM strategies. The most recent set of interviews intended to capture information about: distribution of the PRISM kits, impacts of MCH training and education; strategies used by MCHNs in maternal health; how MCHNs facilitate befriending activities; contacts with GPs; attitudes of Council to maternal health issues; and overall views about participating in PRISM.

From September to December 2001, PRISM research team members conducted telephone interviews with 69 MCHNs participating in PRISM in all the intervention communities ie City of Bayside, Shire of Melton, City of Maroondah, Shire of Mornington Peninsula, City of Greater Bendigo, Glenelg Shire Council, City of Latrobe and Shire of Wellington. All but one of the nurses named on the current MCHN team lists were interviewed. The MCHNs were asked about:

- PRISM kit distribution
- Mothers' responses to the PRISM kit
- Maternal health strategies
- Befriending activities
- Contacts with General Practitioners
- Views about local government and the profile of maternal health
- Overall views about participating in PRISM.

The interview results demonstrate that PRISM has been implemented with the active involvement of MCHNs, including successful distribution of the PRISM kits for mothers, positive overall attitudes to the project and experiences of participating in PRISM, and engagement in initiatives to promote maternal health issues. An account of the major findings is given in the following sections. Comments from nurses are quoted for illustration in Appendix A.

Major findings

A total of 68 MCHNs were interviewed. The majority of MCHNs (78%) had been employed in their local government area since the inception of the project. Fifty-nine percent worked part-time with a mean of 3.2 days/wk (range 1.5 to 4.5 days/wk). Thirty-eight percent worked full time.

PRISM Kit distribution

PRISM kit distribution occurred predominantly at the home visit (66%) with the remaining kits distributed at the first centre visit (8%) usually when there was no home visit. Thirteen percent of nurses who did not distribute kits, were not involved. In 19% of cases kits were occasionally not given out at home visit but were given at first centre visit, if the mother didn't not have home visit or if the nurse had missed or forgotten.

The majority (78%) of the time nurses spent several minutes outlining the purpose of the kit or quite a bit of time discussing the kit with mothers.

In all but two cases nurses reported that they did not have to drop something else from the issues they discussed with mothers in order to include the PRISM information. It was mentioned in 25% of cases that kit distribution did add more time to the visits either at home or at the first centre visit.

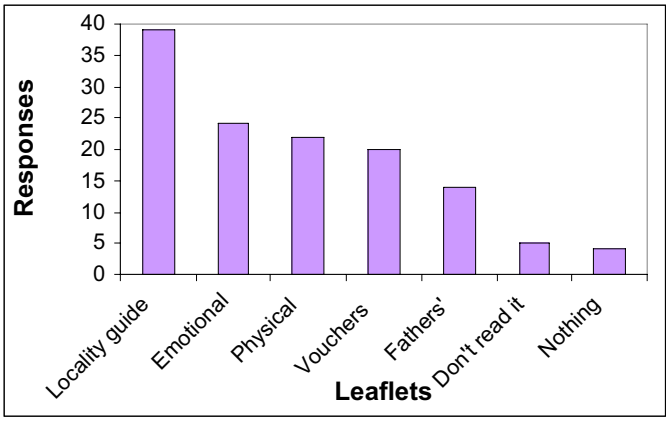
Forty-three percent of nurses reported that they had given kits to all mothers. Giving birth in the study period 44% stated they hadn't been able to give the kit out, (once or twice). Reasons being they forgotten to give them out, had been on leave (and the reliever didn't give them out) or they had run out for that visit. Almost all stated that the mothers were given a kit at the next centre visit.

Nurse views about the value of PRISM kits to mothers

Nurses reported that the parts of the kit they believed mothers found most valuable were: locality guide (57%), emotional health leaflet (35%), physical health leaflet (32%),

vouchers (29%) and fathers leaflet. Nurses often mentioned more than one component of the kit.

Graph 1 Most valuable leaflets for mothers



Providing information once the PRISM kit distribution ceased

Once distribution of the kit ceased (between October and December 2001 for various areas), various strategies for continuing to provide the information in the kit were mentioned. Talking with women about issues mentioned in the kits was the strategy most commonly mentioned with 53% of respondents suggesting this method. Other strategies used to a lesser extent included using noticeboard versions of kit materials, the locality guide being incorporated into the Council's community directory, use 'library' copies for loan and reprinting the kits in some form.

Using other pamphlets was also mentioned; maternal depression and stress (12), maternal physical issues (8), "positive parenting" (7), infant focus such as feeding (5) and supporting your partner (2).

In relation to nurses' attitudes to kit distribution, most were positive and considered it a plus (71%). Being able to use it as an *"avenue to raise women's health", "easy way to bring up topics-provided structure for discussion", "practical, efficient, attractive"* were some of the positive responses to the kit.

The remainder had mixed (4%) or negative views (10%). 15% of nurses did not distribute the kit. Although only a few, the main negative responses centered around the extra time and commitment required to maintain kit distribution, the overload and minimum number of women expressing interest was not enough to make it worthwhile.

Impact of MCH training/education

The majority of MCHNs (84%) had participated in the PRISM training program. Of these, most (74%) interviewed recognised that the training program did change practice in certain ways. Most commonly nurses reported a greater subsequent focus on women's health with comments such as *"probably made me more aware of the importance of asking specific questions about mothers' health",* improving listening skills: *"learning to sit back and just listen"* and improved practice through *"fine tuning interviewing skills/ counselling".*

Interestingly those who felt that training did not affect practice sometimes then acknowledged some impact shown by remarks such as *"more focus on mothers issues"* and *"...but did highlight issues about women's health".*

Since the PRISM training nurses mentioned having participated in other educational sessions on maternal health (See Table 1).

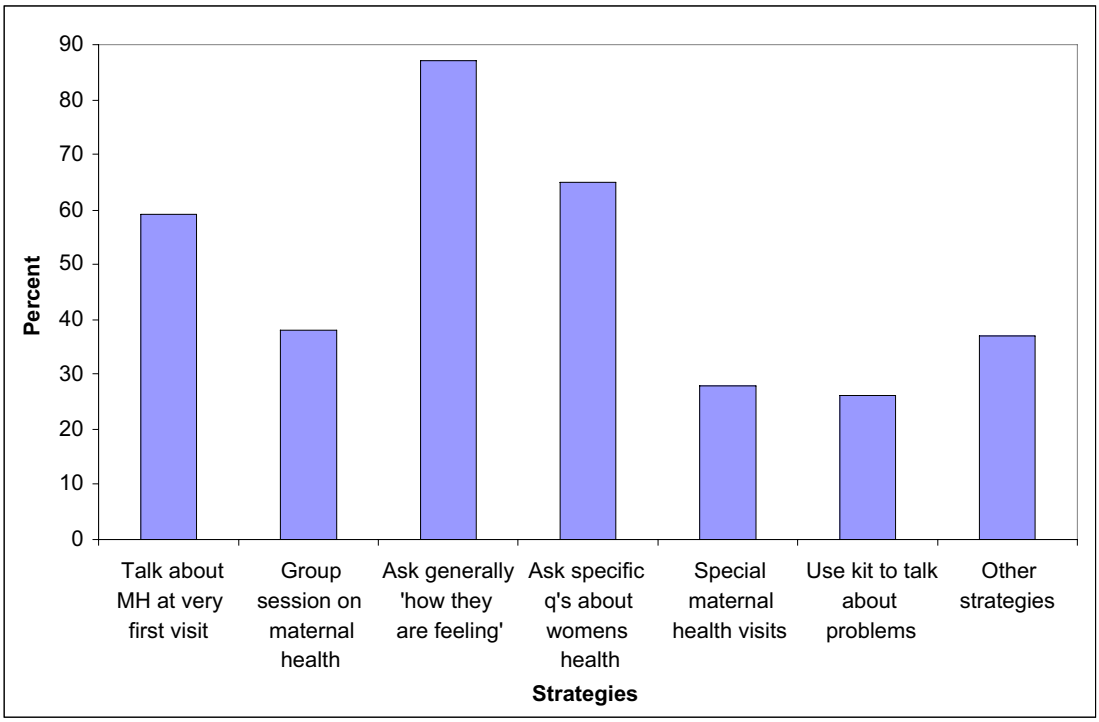
Table 1 Other educational sessions on maternal health

Total n=57	**Number (%) of responses**
Postnatal depression	30 (44%)
Breastfeeding and lactation	20 (29%)
Physical health ie Incontinence, pelvic floor ex, constipation, sleeping	15 (26%)
Sexual health/family planning	10 (18%)
Parenting	8 (14%)
Drugs and alcohol	8 (14%)
Domestic violence	8 (14%)

Maternal Health Strategies

Strategies used for addressing maternal health issues varied within and between communities. Many nurses mentioned a number of strategies. Frequently asking women "how they are feeling" (87%) and asking specific questions about particular health issues (65%) were the main strategies used, followed by raising maternal health issues at first centre visit (59%) (See Graph 2).

Graph 2 Main strategies for attending to maternal health issues



Thirty-five percent of nurses also mentioned other strategies for attending to maternal health issues, including; asking women about their levels of support and suggesting support groups within the community; observing behaviour/ reading cues, use of newsletters and noticeboards and suggesting treatments, for example physiotherapy.

Maternal health information currently displayed in MCH waiting rooms varied within and across LGAs. The frequency with which topics were mentioned is shown in Table 2.

Table 2 Information currently displayed about maternal health in the waiting room

	Number (%) of Responses
Maternal health noticeboard with rotating information	43 (63%)
Information on maternal depression	24 (35%)
Information on urinary incontinence	22 (32%)
Postnatal exercises/weight loss	15 (22%)
Domestic violence/partner abuse	13 (19%)
Information on mastitis	11 (16%)
Breastfeeding/breast self examination	11 (16%)
Parenting	9 (13%)
Pap smears	7 (10%)

Back pain	5 (7%)
Family planning/contraception	5 (7%)
Nothing currently	8 (12%)

Other information mentioned less frequently included: smoking, exhaustion, local groups for mothers/contacting other mothers, relationship counselling, sex after childbirth, "time out" and dietary issues.

Forty-one percent of respondents noted no changes to facilities at their centre in the past two to three years. Of those who had experienced change the main changes included structural improvements and increased access for mothers such as changed entry for twin prams and new baby change tables, changes to work environment for nurses such as computerisation, new desks and new baby weighing scales, repainting and new carpet, noticeboards, improved security systems/ safety gates and provision of shaded areas and play equipment at the centre. Five respondents didn't know about changes in their centre, as they were too new.

Reducing isolation: Befriending opportunities

Multiple activities for reducing isolation and increasing social opportunities for mothers were used by MCHNs. The degree of facilitation with regard to befriending opportunities also varied considerably. Appendix A illustrates the types of facilitation and activities engaged in. Multiple strategies were often mentioned. Table 3 outlines the breakdown of strategies in use.

Table 3 Befriending strategies used by MCHNs

Strategies	Number (%) of MCHNs who mentioned using the strategy
Referral to existing groups eg playgroups	33 (49%)
Suggest that two mothers might get together	26 (38%)
Facilitate activity based get togethers (eg pram walks from centre)	24 (35%)
Distribute newsletters about local activities for mothers	17 (25%)
Advertise drop-in coffee times at Centre	6 (9%)
Setting up a new group	5 (7%)
Have put up a "Meet-a-mother" noticeboard in Centre	4 (6%)
Encourage voucher use with another mother	3 (4%)

Seventy-eight percent of respondents reported that maternal health newsletters were distributed in their area and of those 87% reported that they were available though the MCH Service. A number of comments suggested the newsletters were very popular with

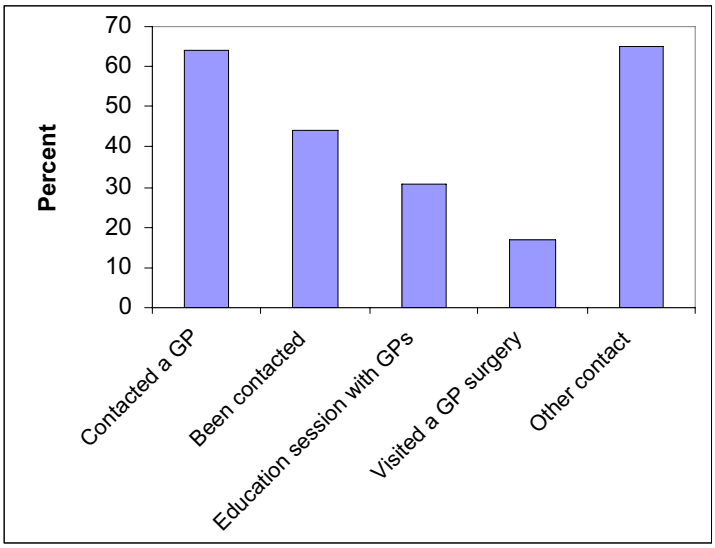
nurses stating that they *"disappeared from the waiting room,"* but most had had very little direct feedback from mothers.

Contact with GPs

Seventy-nine percent of nurses said there had been no change in their contacts with GPs over the last 2 years. It should be noted however that nurses views about existing contact with GPs was a mixture of "quite good anyway" and "always been poor", so the need for change was variable. An important distinction was made between these two groups. Of the 79% of responses where there was no change, there were those who commented that it remained the same and was good (13%) and those that said it remained the same and was poor (6%). The remainder had not commented on the state of the liaison but did mention a variety of reasons why contact had not changed eg centre is too busy, difficult to organise and have tried, but not succeeded.

The remaining 21% of respondents stated contact had improved during that same time period. The variety of contacts is illustrated in Graph 4.

Graph 4 Contact with GP about a maternal health issue in the last 6 months



Other reasons for contact included: baby and child health, social contact, professional contact for their own purpose, (for example MCHN consults the same GP), GPs bring their own children to the MCHN, meetings/steering committees and joint education sessions.

Council and MCH activities

Responses were mixed with regard to MCHN views about the importance of maternal health within Council and with regard to the profile given to the MCH service. Maternal health was not viewed as very important (32%) or only of medium importance (34%) within Council by the majority of respondents. However 15% of these groups (not important or of medium importance) did comment there had been improvements since PRISM began, such as improved pram parking, footpaths and playgrounds.

Typical comments describing the priorities at Council level where maternal health had low importance and there was a lack of council support included:

"Maternal health doesn't start with "R" like roads and rates"
"They're still rates roads and rubbish people"
"Not certain but lower than potholes and amalgamations"

Table 4 Maternal Health importance within Council

MH importance within Council	Percent
Very important	18%
Medium	23%
Not important	22%
Don't know	5%

The MCH service was viewed as having a low profile (34%) or medium profile (32%) within Council by the majority of respondents. However of those a number thought the profile could be improved with some self promotion (15%). Comments such as *"Council have no idea what MCHNs do", "not sure they understand our role"* occurred in 15% of cases, suggesting that the MCHN profile, and understanding of what they do, could be improved with education.

Reasons for the low/medium profile in the majority of cases were also described such as *"working….in centres away from Council", "not really represented at Council, MCHNs do not attend meetings"* and *"no negotiating power."*

Table 5 Maternal and child health profile within Council

MCH profile within Council	Percent
High profile	20%
Medium	22%

Low profile	23%
Don't know	3%

The importance and profile thought to be given by Council was largely consistent across all LGAs.

Overall views of participating in PRISM

Seventy-two percent of MCHNs thought that participation in PRISM was a positive experience while the remainder (22%) had mixed feelings. No one perceived participating as a completely negative experience. Six percent felt too new to comment.

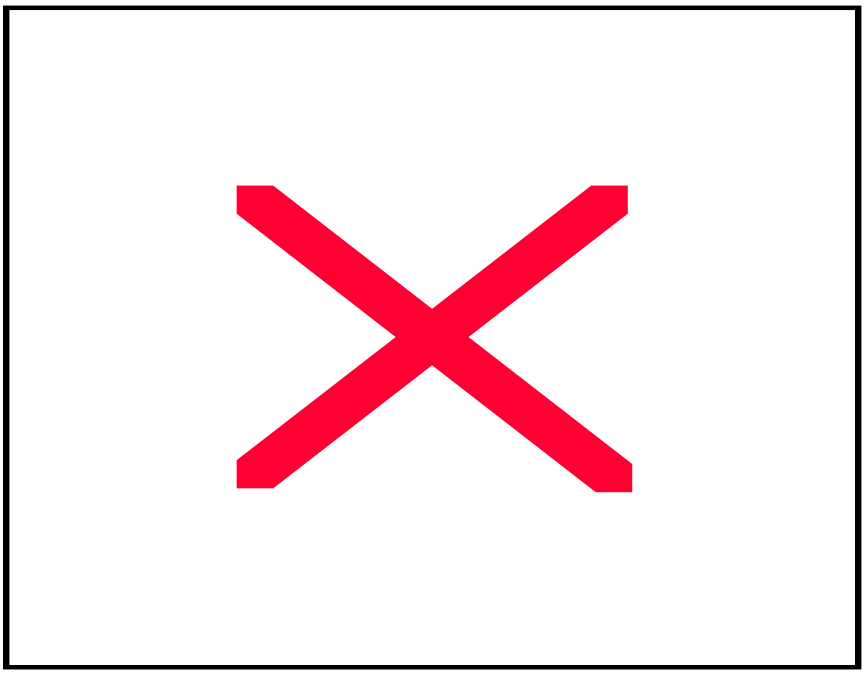
Overall comments were very positive and focused on the following: as a result of PRISM, there was greater concentration on and highlighting of maternal health; the need for the program to be ongoing and implemented elsewhere; the enjoyment and benefit of the PRISM training sessions and the range of contributions made by the community development officers (CDOs).

Most difficult aspect of participation

Time constraints and difficulty fitting everything in was clearly one of the challenges mentioned most frequently (29%). Closely related to the time element were the expectations around the extra burden of activities as a result of the project (or the perception of the increased roles) (12%).

To a lesser extent, perceived lack of support from and expectations of the CDO, as well as not participating in the project from the beginning, were also mentioned as difficulties. Some comments also suggested that mothers lacked interest and were not responsive to the MCHNs' efforts.

Graph 5 Most difficult thing about participating in PRISM



Examples of the types of comments made can be seen in Appendix A.

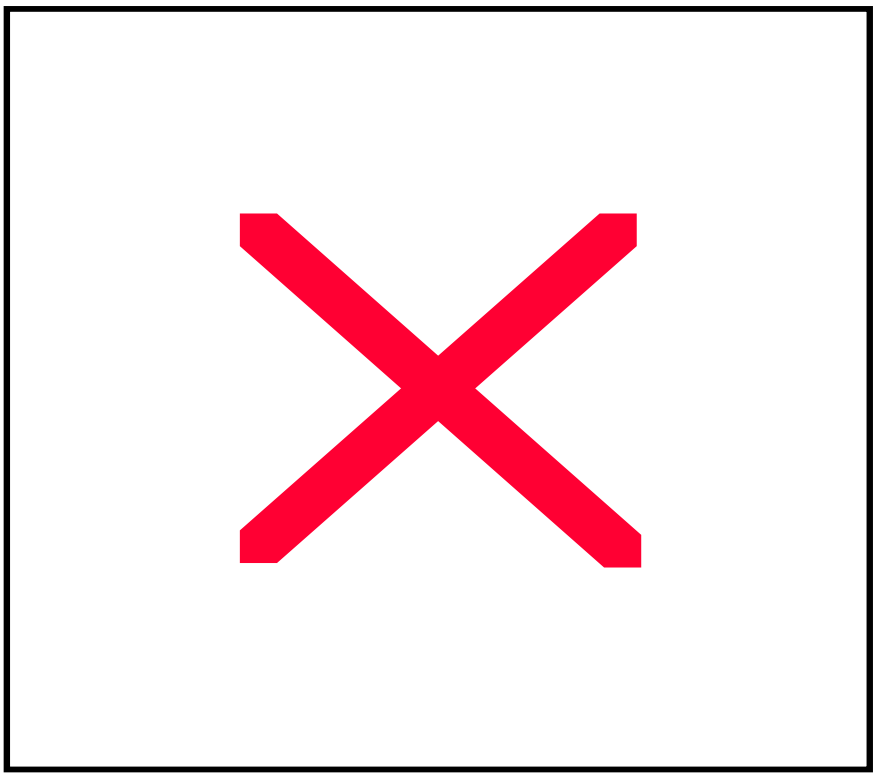
Most exciting/positive aspect of participation

There were clear positive highlights for most respondents. 25% of participants mentioned the format and information in the PRISM Kits. Participation in the training and education sessions was also highly valued by 25% of respondents.

Comments also illustrated the benefit of being reminded of and focusing on maternal health (18%). Similarly being part of a large research project that recognised maternal health was also obviously positive (13%). Respondents also highlighted the positive outcomes as a result of the project, for example establishment of walking groups.

Comments also centered on the way that PRISM validated or helped recognise what MCHNs do; their role. Networking with other areas and contact with other health professionals was also mentioned frequently. Graph 6 illustrates the main responses.

Graph 6 Most exciting or interesting thing about participating in PRISM



Examples of the types of positive comments made can be seen in Appendix A.

Conclusions

In summary, interview responses indicate that maternal and child health nurses mostly felt very positive in about their involvement in PRISM, with the PRISM Kit and its distribution to mothers, as well as maternal health training provided by the project, seen as highlights.

Strategies for attending to maternal health issues appear to have become more focused, with nurses not only frequently asking generally about 'how they are feeling', but also many nurses using specific questioning to encourage women to talk about their health issues.

A variety of befriending initiatives were used to reduce isolation of mothers and increase their opportunities for meeting others in their local community. Sustainability of these activities remains the challenge and nurses particularly saw this as the case when the

community development positions finished, or the Council was not active in supporting initiatives, with commitment and motivation to continue the work suffering as a result.

Findings relating to contact with GPs, and the importance of maternal health and MCH service within Council were not as encouraging. Contact with GPs was mostly seen as not having changed/improved in the duration of PRISM. Nurses felt that some progress had been made in Council views about the importance of maternal health and the MCH service, but most clearly felt further improvements were needed.

For more details of the interview findings, please contact Rhonda Small at the Centre for the Study of Mothers' and Children's Health, 251 Faraday Street, Carlton, 3053. Phone 8341 8542 or email on r.small@latrobe.edu.au.

Appendix A: Range of illustrative comments from the interviews

Maternal health strategies

Some of the innovative **strategies** for attending to maternal health issues are worthwhile reporting

"Letting mother know what resources are available. Normalising problems as an opener. Physio [therapist] attends mothers group (first time mothers)-back pain, incontinence. Making time to listen to women, not have a rigid agenda when the women comes in. postpone baby issues to next visit if maternal issues apparent"

"Now doing enhanced home visiting fulltime. I find that most mothers feel more comfortable to talk at home. Talking about their own health seems to come more easily. They know I'm there for them and not just the baby. Easy to talk about their health issues because you can see how their life is. Everything is their context for talking is there, so I can say: "How do you find the level of that change table for your back?""

"Try and give a positive comment to the mother at the end of the session. Also try to personalise the consultation ie remember/note down when someone has been on holidays. Use the 'ESP' prompts (from GAPP)"

"Befriending" comments

Facilitation of befriending strategies was undertaken in a number of different ways such as

"I'm doing this in relation to specific groups of mothers, set up an African mothers group at the housing centre and I've recently started encouraging teenage mums to go to the young mums group and for mother who have experienced abuse/ have issues with parenting. I've been working with [organisation name] and their "creating capable kids" program and that's turned into a "meet and chat group" for mothers"

"Refer to playgroups, drop in myself to playgroup and sometimes go down with a mother to introduce her to the group"

" I ran one-off informal group sessions on topics (eg toilet training) with coffee that all mothers came too and I emphasise that it's a chance to meet other mothers"

Some other comments around **suggesting one-to-one introduction** of mothers include

“Sometimes make appointment close to a women who lives nearby or who speaks a similar language”

“"Someone 6 houses down" joint appointment two mothers. I'll say "Did you know there's another mother six houses down?" I've had success making appointments for such mothers, one after the other and introduced them that way. One pair of mothers I did this with now always come together to see me!”

“.....occasionally puts multis with “big gap” in childrens ages in contact with each other…”

Comments about what was most “interesting or exciting” about PRISM participation

Overall the comments were positive. The MCHNs felt it was a very worthwhile project to have been involved with and that it highlighted the importance of maternal health.

The most positive aspect was the information and format of the **kits** with comments such as

“Kits have been very good, very helpful. Helped me to learn more as it helped me to explain the kit to mothers”

PRISM **education and training sessions** were highly valued with comments like

“I did enjoy the teaching sessions, it refreshed things for me. Helped me pull my socks up. Also in other ways I could feel, well that’s good”

“MCH training days were interesting mainly because they reinforced what we were doing”

Focusing on and being reminded of importance of **maternal health**

“ The focus on maternal issues. Encouragement for supportive measures for depression-changed my perspective on this greatly. Now see depression as reaction to stresses in women’s lives”

“PRISM has been an "awakening program", good for my practice reminding me about mothers health. Talking about PRISM has given mothers a sense that people care, they're not alone and its important to talk about health and problems. It's also been a focus for change that's non-threatening, you can say "as part of the PRISM program about supporting mothers are there ways that you service eg change room can be improved?”"

Networking

"Working with other people in other places working with CDO past and present. Seeing the changes that have come about"

Recognition

"Getting information for mothers and acknowledging the work we (MCHNs) do is important. PRISM recognised our role. It came following CCT and it was lovely to have someone say we were doing a good job. Made me feel good"

Comments about what was most difficult in PRISM participation

Time constraints and **expectations** of the extra duties required were highlighted with comments such as:

" Expectations of MCHNs perhaps too high. Insufficient time to take on new initiatives especially group activities"

"Difficult to fit discussion in about maternal health in the time available, felt pressured by what was being asked of MCH nurses"

But sometimes difficulties turned into positives:

"Awareness of time and the need to structure and allocate time for activities"

"Expectations regarding contacting GPs was a bit much but needed time to get into that, did enjoy it when I did"

Support and expectations of **CDOs** proved to be an issue for some nurses illustrated by:

"A bit of friction between CDOs and nurses…, they thought we were blocking them, when really it was a matter of how much time in the day, different agendas (community development role v's individual clinical role). They thought we weren't listening sometimes and we thought they weren't"

"The PRISM worker asked us to do a lot of things beyond our role ie welcome mothers to the centre before walking group. It wasn't realistic. We didn't have time, we're paid to consult."

"Pressure from CDOs to facilitate groups, felt CDOs didn't understand the pressures of MCH job……."

Feedback from women was also seen as a difficulty with comments such as

"Women were not responsive to initiatives, I began to wonder if we were on the right track with ideas about sorts of things that might be of benefit to women"

"Getting mothers to participate and be committed, for example to the walking group"

Not participating from the beginning of PRISM was also a challenge:
"Didn't participate from the start and wasn't clear about what it involved"

"As I had not been there from the inception-not really involved……."

Appendix B: Interview questions

Interview Schedule for MCH Interviews Sept/Oct 2001

We are interested in your feedback about implementing aspects of the PRISM project over the past three years. The interview will be similar to the ones we did with MCH nurses almost two years ago. It should take about 15 minutes.

1. First, have you been a member of the MCH team in [LGA] since the beginning of 1999, about the time PRISM began?

2. Do you work full time or part time?

3. Thinking about the distribution of the PRISM Information Kit to mothers, have you given it to mothers at the home visit or at the first centre visit?

4a. How do you talk about the kit when you first give it to a mother?

4b. Has the time you spend on discussing the kit when you first give it out, meant that you have dropped something else from the issues you discuss at this visit?

4c. What things?

4d. Do you take these up later?

4e. Has there been any time when you haven't been able to give a mother the kit?

Why was that?

5. What components of the Kit do you think mothers find most valuable?

6. When copies of the Kit run out, what strategies, if any, will you use for providing the type of information contained in the Kit?

7a. Having distributed the kit for some time now, would you say overall that giving out the kit has been a plus, or a burden for you (just another thing to fit in)?

8. Thinking back to the PRISM training program run in 1999 and the refresher session early last year (2000), did the sessions in any way affect or change your practice as a maternal and child health nurse?

For nurses not involved in the training**:**
9. Have you heard anything about the PRISM training program, or seen any of the training materials?

10. Have you attended any other educational session(s) on a maternal health topic in the last two years?

11. Thinking about your own practice, describe the main strategies you use for attending to maternal health issues in the first year after birth.

12. Now, thinking about the Centre where you work most often, what information, if any, is currently displayed about maternal health in the waiting room?

13. Have there been any changes or improvements to facilities at your centre in the last two to three years?

14. We know that mothers often feel isolated at home with young babies. It can be hard to meet other people or maintain connections at this time in women's lives. Apart from running groups for first-time mothers, what kinds of things do you do to help mothers feel less isolated and increase their opportunities for getting out and meeting people?

15. Is there a newsletter for mothers currently distributed in your area?

16. Is the newsletter available through the MCH Service?
Where is it available?

17. What do mothers think of the newsletter?

18. Thinking now about communication and liaison with general practitioners, would you say there have been any changes in your contacts with GPs over the last two years?

19. In the last six months, have you done any of the following:

20. Turning now to local government, what importance do you think maternal health has within Council?

21. And what kind of profile does the MCH Service have within Council?

22. Thinking then about your personal involvement with PRISM overall, has it been:

23. What was the most difficult thing for you about participating in PRISM?

24. What was the most interesting or exciting thing?

25. Finally, given that we have asked about some very specific aspects of PRISM, are there any other comments you'd like to make?