

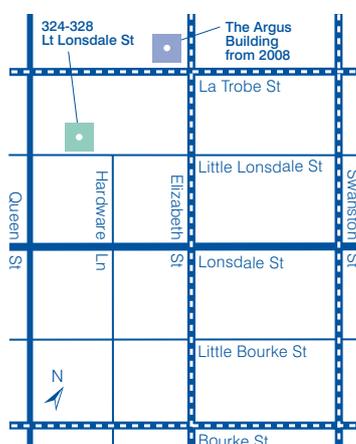
MCHR: On the move

After six years at the Kathleen Syme Building in Faraday Street Carlton, the Centre is re-locating. Moving day, expected in the second half of January 2007, is fast approaching. We are packing up ready to move to a new temporary home at 324-328 Little Lonsdale Street, near Queen Street. For eighteen months or so MCHR will be around the corner from where the Australian Institute of Family Studies is located (until they move in mid-February!). Our phone and fax numbers will be unchanged.

La Trobe University is also currently redeveloping the former Argus Building, a unique Beaux-Arts style building of the late 1920s period, located on the corner of Elizabeth and La Trobe Streets. We will join our colleagues from the Australian Research Centre in Sex, Health & Society, and others, in the Argus Building during 2008.

Visitors to the Centre can reach our new home at 324-328 Little Lonsdale Street via:

- tram (Swanston, Elizabeth, William or La Trobe Streets);
- train (Melbourne Central or Flagstaff stations);
- bus (routes to Lonsdale Street and Queen Street); or
- car (pay car park is opposite).



Mother & Child Health Research

324-328 Little Lonsdale Street
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We will miss the Carlton precinct, but we look forward to exploring our new CBD environment.

Celebrating NHMRC grant success

Staff at the Centre were delighted with the outcome of this year's round of National Health and Medical Research Council (NHMRC) funding. We were awarded a Capacity Building Grant in Population Health with five years' funding (\$2.3m) to support postdoctoral researchers engaged in developing a program of public health research focusing on *Building public health capacity for complex questions, complex populations and complex interventions*.

This program of work, led by Judith Lumley, will enable us to extend our current research addressing complex public health issues ranging from intimate partner violence to preterm birth and substance abuse. The focus will be on building capacity for conceptualising complex

questions; working with populations who are often excluded from research, including Indigenous communities, immigrants and refugees and women experiencing intimate partner violence; and designing and evaluating complex interventions in diverse settings ranging from hospitals to primary care and communities.

Research program focused on:

Complex questions

- Maternal health
- Intimate partner violence
- Unwanted pregnancy
- Preterm birth
- Cervical dysplasia
- Depression
- Breastfeeding
- Substance abuse
- Smoking cessation

Complex settings

- Primary care
- Hospitals
- Communities

Population groups

- Women & children
- Indigenous communities
- Immigrants/refugees

Complex Interventions (well-designed & implemented)

- Community trials
- Multi-centre studies
- Multi-level interventions
- Health service Evaluations
- Health economic evaluations

Supported by capacity building activities to enhance research effort

Public health benefits

- Stronger research capacity
- Improved research
- Sound health policy
- Better health care
- Improved health

The lead investigators on the Capacity Building Grant are: Prof Judith Lumley, A/Prof Stephanie Brown, Prof Jane Gunn (University of Melbourne), Dr Rhonda Small, A/Prof Jeanne Daly and Prof Christine MacArthur (University of Birmingham).

Researchers at MCHR are also involved in two other NHMRC funded projects:

Dr Helen McLachlan from the School of Nursing and Midwifery, Dr Della Forster, Ms Mary-Ann Davey and Prof Judith Lumley (MCHR) together with Ms Tanya Farrell and Prof Jeremy Oats (The Royal Women's Hospital) received \$583,000 for the first randomised controlled trial in Australia of caseload midwifery care for women at low risk of complications.

A/Prof Kelsey Hegarty and Prof Jane Gunn from the Department of General Practice, University of Melbourne, Dr Angela Taft (MCHR), Prof Gene Feder (University of London), Prof Jill Astbury (Victoria University) and A/Prof Stephanie Brown received \$654,000 for a randomised trial in general practice evaluating an intervention into partner abuse and violence.

A Hierarchy of Evidence for Qualitative Research

Jeanne Daly

In the process of writing a book about the evidence-based medicine movement, I was alerted to the years of hard work that the pioneers of the movement had committed to developing their methods. The basis for clinical decision making about treatments or interventions, they argued, must be good evidence of what works and what does not. The first task was to reach agreement on criteria for defining good evidence. This is how Gordon Guyatt from McMaster University described how they use the idea of criteria for good evidence in educating researchers and clinicians:

*What we talk about is applying certain rules and concepts of science to clinical experience and systematizing it. 'How do you know that treatment x works?' 'Well I gave it out and the person did well.' OK. And then you say, 'But to what extent can you be confident?' You find out very quickly that you can't be confident at all. And then you say, 'OK, well how can I be more systematic in my accumulation of clinical information to strengthen my inference?' And if you push it, you end up with a double blind randomized trial as a systematic way of accumulating clinical experience. ... And now is clinical experience worthless? No, but with the appropriate level of skepticism and knowing how things go wrong.'*¹

Gordon Guyatt is describing the well-known hierarchy of evidence as it applies to medical treatments or interventions. Heading the list is the randomised controlled trial or, even better, systematic review of high quality randomised trials. At the low end is clinical opinion. When this hierarchy first became popular, there was a tendency to place qualitative research at or below the level of clinical opinion. Of course, we objected, vehemently, pointing out that the major use of qualitative method is not to test the effectiveness of interventions but to study other aspects of health and health care. Some suggested

that qualitative researchers make their contribution by studying how the evidence from evidence-based medicine is implemented in clinical care; others pointed to a large field of study that is excluded if we focus only on interventions.

For those of us convinced that we were making an important contribution to knowledge about clinical care in our qualitative studies, there was a stumbling block: the poor quality of many qualitative studies published in the medical and allied health literature. While we knew them to be of poor quality, and among health sociologists it was easy to reach agreement about what is a good study and what is a poor one, there was little agreement about what the explicit criteria were for making such judgments. If we did not feel the need for criteria, the problem was that reviewers and editors of some leading medical journals were (in our humble opinion) in need of a set of clear guidelines for judging what is a high quality qualitative study with results that can be confidently incorporated into clinical decision making.

A few years back a group of us started meeting to define a set of criteria for judging the strength of evidence for practice from qualitative health research. Some of us are health sociologists but our membership represents the range of disciplines with an interest in conducting or judging qualitative research. We started by collecting recent qualitative papers, making a judgment about the quality, and then defining the criteria that we were using. While there was good agreement on the quality of papers, defining the criteria was fraught with difficulties. Those of us who are sociologists found it particularly difficult to define criteria that might be used to restrict the flexibility of our research practice but there was clear evidence of the need for such criteria with growing evidence of the variable quality of this research.

Our qualitative hierarchy of evidence-for-practice is now in press in the *Journal of Clinical Epidemiology*. For readers with access to Elsevier publications, the paper is already available free online as an in-press paper.² Others have to pay for the privilege of reading it now, or have to be patient a little longer.

Jeanne Daly is an Adjunct Associate Professor at MCHR.

1. Daly J. **Evidence-based Medicine and the Search for a Science of Clinical Care**, University of California Press and Milbank Memorial Fund, 2005, p88.
2. Daly J, Willis K, Small R, Green J, Welch N, Kealy M, Hughes E. *A hierarchy of evidence for assessing qualitative health research*. **J Clin Epidemiol** (in press).

Emergency contraception in Australia: over-the-counter provision

Melissa Hobbs

The emergency contraceptive pill (ECP), in the form of the package Postinor-2 (two single tablets of progestogen only), became available in Australia as a pharmacist-only medication (S3) in January 2004. Since this rescheduling, making it possible for ECP to be provided over-the-counter (OTC) without a doctor's prescription, there have been no Australia-wide studies assessing whether there has been any change in satisfaction with and acceptance of ECP among women and pharmacists or any change in abortion rates.

Australia's teenage abortion rate is one of the highest in the developed world. Among 16-59 year old Australian women, 22.6% have had one or more abortions.¹ Teenage women seek abortions at a later gestational

age and their pregnancy outcomes are often more adverse than those of older women.² Rates of unplanned and unwanted pregnancy are a major public health concern. The availability of ECP through Australian pharmacies could potentially make significant differences to rates of ECP use and reduce unwanted and unplanned pregnancies and abortion rates in Australia.

This ARC-Linkage funded project aims to assess whether the rescheduling of ECP in Australia has improved its accessibility and use by women at risk of unwanted pregnancy. It will also assess whether pharmacists feel confident, well-trained and supported to provide it and whether abortion rates have reduced. The study will provide policymakers with the evidence to assess whether the provision of over-the-counter ECP is effective and what is needed to improve its effectiveness.

The study will use both qualitative and quantitative methods, involving:

- focus groups with women users of ECP (16-52 years) to explore knowledge of, access to, attitudes towards, and experiences of using ECP;
- focus groups and interviews with pharmacists who have been involved in the provision of ECP to explore training, attitudes and practice;

- Computer Assisted Telephone Interviews (CATI) with a random sample of Australian women, and a national survey of pharmacists, developed using the information obtained from the focus groups; and
- trend analysis of abortion data.

Recruitment of women for focus groups is expected to commence in January 2007. Ethics approval has been obtained from La Trobe and Monash Universities and Family Planning Victoria and is pending from Deakin University.

Melissa Hobbs is an ARC doctoral scholar supervised by Angela Taft, Judith Lumley and Kay Stewart (Victorian College of Pharmacy).

1. Smith, AMA, Rissel, CE, Richters, J et al. *Reproductive experiences and reproductive health among a representative sample of women.* **Aust N Z J Public Health** 2003;27:204-9.
2. van der Klis KAM, Westenberg, L, Chan, A et al. *Teenage pregnancy: trends, characteristics and outcomes in South Australia and Australia.* **Aust N Z J Public Health** 2002;26:125-31.

Melissa Hobbs



Lesbians are mothers too

Jenny Kelly

There are approximately 60,000 births in Victoria each year. It is not known how many of these babies are born to mothers who identify as lesbian or same-sex attracted. What is known, however, is that an increasing number of lesbians are choosing to become parents. A recent Australian study indicated that 20% of lesbians, gay men and bisexuals have children and many more are planning to have children in the future.¹ Although more lesbians and gay men are raising children, societal attitudes towards same-sex parents remain negative and discriminatory. Much of the research that has explored the topic of lesbian families has focussed on the psychological outcomes of children of lesbian and gay parents, and on differences between lesbian parenting and heterosexual parenting. There is a lack of Australian research that explores lesbians' experiences of maternity care.

Numerous Australian and international

studies indicate that lesbians frequently encounter discrimination when interacting with the health service system.²⁻⁴ This discrimination often leads to delay in accessing services and/or reluctance to seek out health care. Heterosexist assumptions and lack of knowledge of lesbian health concerns by health care providers continues to promote lesbian invisibility and is often cited by lesbians as a reason for not disclosing their sexual orientation.

The aim of this study is to explore the views and experiences of a sample of lesbians who gave birth in Victorian public hospitals between 2000-2006. In doing so we will identify and document the unique experiences lesbians encounter during their interactions with the public health system throughout their pregnancy and postnatally. In addition, we will compare the findings with a similar project conducted in the United Kingdom.⁵ The findings will then be used to develop educational resources for health professionals.

Lesbian/same-sex attracted women who gave birth in any public hospital in Victoria during 2000-2006 are eligible to participate in the study. Women taking part in the study are asked to complete a confidential questionnaire and a sub-sample will be invited to participate in a follow-up

interview. Recruitment and data collection are currently under way.

Jenny Kelly is a Research Associate at MCHR and is collaborating with Stephanie Brown to conduct this study. The project is funded by a small grant from the Australian Lesbian Medical Association and AIDS Council of New South Wales.

1. Millbank J. **Meet the Parents: A Review of the Research on Gay and Lesbian Families.** *Gay and Lesbian Rights Lobby, NSW, 2002.* <http://www.girl.org.au>
2. Brown R. **'More Than Lip Service': The Report of the Lesbian Health Information Project.** *Royal Women's Hospital, Victoria, 2000.*
3. Kelly J. **Zest for Life: Lesbians' Experiences of Menopause.** *Spinifex Press, North Melbourne, 2005.*
4. Koh AS. *Use of preventative health behaviors by lesbian, bisexual and heterosexual women: questionnaire survey.* **West J Med** 2000;172:379-85.
5. Royal College of Midwives. **Maternity Care For Lesbian Mothers: Position Paper 22,** London, 2002, <http://www.rcm.org.uk>

Jenny Kelly



PRISM: reflecting on findings of no effect

Judith Lumley

It is just over four years since the *PRISM* team published the protocol for this trial,¹ and relatively soon afterwards that we saw the data on the outcomes. The complex intervention had been designed to reduce maternal depression and physical health problems and to increase support for mothers in the year after birth. What we found was that there were no differences at all between the municipalities that had been randomised to receive the *PRISM* intervention and those who had not.² This was not an equivocal or borderline finding: the similarities were so close that no-one could make a case that with a little more effort or time the intended benefits of the intervention would have emerged.

Our experiences after the trial was completed showed that some of our expectations had been naïve. We expected that *PRISM*'s design, size and scope, thorough analysis and the importance of reducing depression in recent mothers made the paper of substantial interest and highly appropriate for publication. The women who took part included city and country populations across the whole spectrum of areas in Victoria, suggesting that the findings were relevant across the State. Our expectations were completely wrong: two leading journals rejected the paper, taking almost two years to do so. We persisted: the result being acceptance of the paper by *BMC Public Health* at the end of 2005.

Publication in *BMC Public Health* provided some major benefits. We were encouraged to use the *PRISM* website³ as a resource for the paper which allowed readers direct access to all the materials and the publications that came out of *PRISM*.

It also provided direct access to the abstracts of almost all references and information on how many times readers had downloaded a copy of the *PRISM* paper.

What did we learn from this difficult two years? One thing we learned was that even uninformed reviewer comments can be helpful. One reviewer mentioned that she

did not know there had been any randomised trials on this topic so we added a Table including all the published trials which aimed to prevent postnatal depression. The Table made it very clear that with one exception, these strategies were ineffective. The one successful trial involved a strong collaboration between midwives (delivering an extended program of home visits) and the GP practices they were part of. That most of the trials proved ineffective raised the possibility that the whole approach might be wrong. The trials in the Table were all - in their very different ways - trying to provide additional support for women. The belief that it is lack of support that contributes to depression after birth is widespread but it may be only a part of the picture.

The next task is to analyse the picture of women's mental and physical health from the communities participating in *PRISM* two years after giving birth. To what extent did women who were depressed after birth recover? Were women in both arms of *PRISM* less likely to be depressed than they had been six months after birth? Were there any significant differences between the LGAs which had implemented the intervention and those providing standard care? This will be a complex analysis, dealing with change in all the individual women as well as community differences.

One important fact that we learned - or re-learned - is that if we had carried out the *PRISM* intervention without designing it as a randomised trial the strongly positive comments from all those involved (women, Maternal and Child Health Nurses, participating communities, researchers), which we heard when we talked with people about the trial would have been taken as evidence that it had worked really well. Aspects of *PRISM* might well have been implemented elsewhere or sustained in some of the areas where it had been implemented. Thus, randomised trials, however difficult to carry out well, make an essential contribution to identifying what is effective care.

1. Lumley J, Small R, Brown S, Watson L, Gunn J, Mitchell C, Dawson W. *PRISM (Program of Resources, Information and Support for Mothers) Protocol for a community-randomised trial [ISRCTN03464021]*. *BMC Public Health* 2003; 3:36.

2. Lumley J, Watson L, Small R, Brown S, Mitchell C, Gunn J. *PRISM (Program of Resources Information and Support for Mothers): a community randomised trial to reduce depression and improve women's physical health six months after birth [ISRCTN03464021]*. *BMC Public Health* 2006; 6:37.

3. *PRISM: Program of Resources, Information and Support for Mothers - Project Website*: www.latrobe.edu.au/mchr/prism



Sexual health in pregnancy and after childbirth

Ellie McDonald

There is very little research evidence regarding changes affecting women's sexual health during and after pregnancy, or about longer-term implications of these changes for relationships between couples.^{1,2} This study is investigating factors associated with sexual health and intimate partner relationships using both quantitative and qualitative methods.

The quantitative aspect of the study will draw on data collected in the *Maternal Health Study*, a prospective cohort of nulliparous women recruited in early pregnancy and followed for four years postpartum (n=1543).

All *Maternal Health Study* questionnaires and telephone interviews include detailed questions about sex and changes in intimate partner relationships. Questions to be addressed include:

- How physically pleasurable for women is sex during pregnancy and postpartum? How closely is this tied to emotional and other aspects of intimate partner relationships?
- When do women first have sexual or intimate contact again after giving birth to their first child? How common is it for women to experience significant pain or discomfort the first time they have vaginal sex after having a baby and how long after the birth does this continue? What other factors (lack of time, exhaustion, body image, relationship problems, depression, other health issues) have an impact on sex after childbirth?
- Are women encouraged by pregnancy care providers to discuss questions about sex during and after a pregnancy? Are there issues women (and/or their partners) would have liked to have known more about, but were not confident to discuss with care providers either during pregnancy or subsequently?

The qualitative aspect of the project will consist of in-depth interviews with a sub-sample of 40-50 women taking part in the *Maternal Health Study*. Interviews will be conducted two years after the birth of their first child, and will provide an opportunity to explore a broad range of issues related to sex and intimate partner relationships. The main objectives of the interviews will be:

- to elucidate the ways in which women understand changes affecting their sex lives and intimate relationships after the birth of their first child;
- to find out what helped women to cope with changes and difficulties during pregnancy and the first year after their baby was born; and
- to explore women's views about the support (or lack of support) they received from health professionals, partners and other family members.

Ellie's doctoral thesis is supervised by Stephanie Brown and Annette Street (School of Nursing and Midwifery, La Trobe University).

1. Barrett G, Pendry E, Peacock J et al. Women's sexual health after childbirth. **BJOG** 2000;107:186-95.
2. Glazener CMA. Sexual function after childbirth: Women's experiences, persistent morbidity and lack of professional recognition. **BJOG** 1997;104:330-35.

Ellie McDonald



Stillbirth: explained, unexplained or unexplored?

Mary-Anne Measey

The term 'unexplained fetal death' (UFD) is often inappropriately assigned to deaths that have not undergone postmortem investigations as well as to deaths for which no cause can be found. It is, however, unclear how many fetal deaths are truly unexplained with different methods of ascertainment leading to estimates between 15% and 60% and little is known about the risk factors and cause.^{1,2}

The availability of linked perinatal, morbidity, mortality and other health related databases in Western Australia provides an opportunity to study the epidemiology of UFD in the Australian setting. Using these and other data, I am undertaking a case-control study on UFD for my PhD. The aim of this whole of population-based study is firstly to determine the true rate of

unexplained fetal deaths (those remaining unexplained despite post-mortem investigations), secondly to identify risk factors for UFD and thirdly to investigate the outcomes of other pregnancies to affected women.

The first stage of this project involved reviewing all fetal deaths occurring in WA from 1990 to 1999 and identifying those that underwent complete post-mortem (PM) investigations. The cause of these deaths was classified using PM results and clinical information as well as death certificate data alone.

Of the 1825 fetal deaths from 1990 to 1999, 53% underwent appropriate PM investigations. Based on PM results and clinical information, 22% (176/789) of these were classified as unexplained and 18% were associated with fetal growth restriction. Other major causes included spontaneous preterm birth (13%), congenital malformations (10%), specific perinatal conditions (10%), and hypertension (7%).

Using death certificate data alone to classify the cause of death, 42% were identified as UFD. Of these 64% were later explained by PM investigations. This suggests the need to define UFDs as those that remain unexplained despite PM investigations.

The next stage of the research involves analysing the linked population data. It is hoped that this study will assist efforts to identify women at risk of UFD and other adverse outcomes and help inform larger population-based studies addressing this important issue.

Mary-Anne is a student of the Telethon Institute for Child Health Research (ICHR), Perth, supported by a NHMRC scholarship and supervised by Dr Adrian Charles (King Edward Memorial Hospital and UWA), Dr Edouard Tursan d'Espaignet (ICHR) and Professor Nick deKlerk (ICHR). Mary-Anne joined MCHR in March this year as a visiting scholar.

1. Fretts RC. Etiology and prevention of stillbirth. **Am J Obstet Gynecol** 2005;193(6):1923-35.
2. Froen JF, Arnestad M, Frey K, Vege A, Saugstad OD, Stray-Pedersen B. Risk factors for sudden intrauterine unexplained death: epidemiologic characteristics of singleton cases in Oslo, Norway, 1986-1995. **Am J Obstet Gynecol** 2001;184(4):694-702.

Mary-Anne Measey



Farewell

It is with much sadness that we farewell **Stephanie Brown** and **Jane Yelland**, as well as members of the *Maternal Health Study* team.

Stephanie is taking up a new position at the Murdoch Childrens Research Institute (MCRI) in February 2007, with associated research staff also transferring to MCRI.

Stephanie was a founding staff member at MCHR when it was established in 1991 and Jane joined us later in the same year. They have both made huge contributions to the development of the Centre, particularly in relation to our health services research in maternity care, our cross-cultural research and our work on maternal physical and emotional health. They and the *Maternal Health Study* team will be very missed.

Stephanie and Jane will continue to be involved in the new Capacity Building Grant which will now encompass a broader collaboration between MCHR, the Department of General Practice at Melbourne University and the Murdoch Childrens Research Institute.

Other Centre news

The *MOSAIC* team is pleased to welcome **Catherine Plunkett** as the second *MOSAIC* Co-ordinator, working together with **Viv Woska**. Catherine brings her 15 years experience in management and direct service delivery in women's domestic violence services in Australia and New Zealand to *MOSAIC*. She combines her work with *MOSAIC* with some part-time policy work at the Federation of Community Legal Services.

Sharon Rayner, a public health trainee, joined the Centre for three months to work on two projects: a project investigating the feasibility of offering women alternatives to standard postnatal care; and another exploring the feasibility of telephone peer support for breastfeeding in the Victorian context. Sharon made an enormous contribution to both studies. She enthusiastically and meticulously organised and facilitated a number of focus groups and interviews with women for both projects, as well as further developing and refining the focus group questions prior to use and undertaking initial data analysis. Sharon also contributed to the analysis of a

survey on private postnatal care provision.

We were very pleased recently to host **Claire Loosmore**, a fourth year physiotherapy student from the University of Melbourne, on a four-week professional development placement at the Centre. Claire was enthusiastic to learn about the work of a public health research unit and made a significant contribution to a range of research support tasks during her time with us.

Jo Rayner, **Mary-Ann Davey** and **Fiona Bruinsma** completed their two year term as editors of the *Australasian Epidemiologist* in October 2006. **Lyn Watson** and **Jo Rayner** were on the organising committee for the *Australasian Epidemiological Association Conference* held in Melbourne, 17-19 September 2006.

Lisa Amir chaired the scientific committee of the *Australian Lactation Consultants Association National Biennial Conference* held in Melbourne, 26-28 October 2006.

Recent publications

Amir LH, Lumley J. Women's experience of lactational mastitis - 'I have never felt worse'. **Aust Fam Physician** 2006; 35(9): 745-47.

Amir LH. Breastfeeding: managing 'supply' issues. **Aust Fam Physician** 2006; 35(9): 686-89.

Amir LH, Garland SM, Lumley J. A case-control study of mastitis: nasal carriage of *Staphylococcus aureus*. **BMC Fam Pract** 2006; 7:57.

Daly J, Willis K, Small R, Green J, Welch N, Kealy M, Hughes E. A hierarchy of evidence for assessing qualitative health research. **J Clin Epidemiol** 2006 (epub).

Forster DA, McLachlan HL, Lumley J. Factors associated with breastfeeding at six months postpartum in a group of Australian women. **Int Breastfeed J** 2006; 1:18.

Forster DA, Denning A, Wills G, Bolger M, McCarthy E. Herbal medicine use during pregnancy in a group of Australian women. **BMC Pregnancy Childbirth** 2006; 6:21.

Forster DA, McLachlan HL, Yelland J, Rayner J, Lumley J, Davey MA. Staffing in postnatal units: is it adequate for the provision of quality care? Staff perspectives from a state-wide review of postnatal care in Victoria, Australia. **BMC Health Serv Res** 2006; 6:83.

Small R, Lumley J, Yelland J, Brown S. The performance of the Edinburgh Postnatal Depression Scale in English speaking and non-English speaking populations in Australia. **Soc Psychiatry Psychiatr Epidemiol** 2006 (epub).

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