



## Women's perceptions and experiences of fetal macrosomia



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### ABSTRACT

**Objective:** to explore women's perceptions and experiences of pregnancy and childbirth following birth of a macrosomic infant (birth weight  $\geq 4000$  g).

**Methods:** a qualitative design utilising interviews conducted 13–19 weeks post partum in women's homes. The study was conducted in one Health and Social Care Trust in Northern Ireland between January and September 2010. Participants were identified from a larger cohort of women recruited to a prospective study exploring the impact of physical activity and nutrition on macrosomia. Eleven women who delivered macrosomic infants participated in this phase of the study.

**Findings:** four overarching themes emerged: preparation for delivery; physical and emotional impact of macrosomia; professional relations and perceptions of macrosomia. Findings highlighted the importance of communication with health professionals in relation to both prediction of macrosomia and decision making about childbirth, and offers further understanding into the physical and emotional impact of having a macrosomic infant on women. Furthermore, there was evidence that beliefs and perceptions relating to macrosomia may influence birth experiences and uptake of health promotion messages.

**Key conclusions and implications for practice:** this study provides important insight into women's experiences of macrosomia throughout the perinatal period and how they were influenced by previous birth experiences, professional relations and personal perceptions and beliefs about macrosomia. Pregnant women at risk of having a macrosomic infant may require extra support throughout the antenatal period continuing into the postnatal period. Support needs to be tailored to the woman's information needs, with time allocated to explore previous birth experiences, beliefs about macrosomia and options for childbirth.

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### Introduction

Fetal macrosomia (birth weight  $\geq 4000$  g) has implications for maternal and neonatal morbidity including increased risk of instrumental childbirth, emergency caesarean section, and birth injury (Jolly et al., 2003). Known maternal risk factors for macrosomia include obesity, excessive gestational weight gain and gestational diabetes (Sebire et al., 2001; Surkan et al., 2004; Ng et al., 2010). Evidence suggests that rates of fetal macrosomia are increasing in westernised societies (Kramer et al., 2002; Ng et al., 2010) and the concurrent rise in rates of obesity may be more than coincidental in light of previous research proposing that metabolic programming for obesity begins with over nutrition in the womb (Dyer and Rosenfeld, 2011). There is currently limited evidence exploring the experiences of women delivering macrosomic infants however, existing evidence on traumatic

birth experiences (Ayers, 2004; Waldenstrom et al., 2004) combined with the known adverse outcomes associated with fetal macrosomia (Mocanu et al., 2000; Jolly et al., 2003; Bjorstad et al., 2010) suggests potential for a less than optimal birth experience. Birth experiences may impact on future reproduction (Gottvall and Waldenstrom, 2002), breast feeding (Beck and Watson, 2008), maternal psychological health (Ayers, 2004) and on infant behavioural and emotional development (Latva et al., 2008). In particular, optimal birth experiences are associated with a positive attitude to motherhood and increased self-esteem (Simkin, 1991).

Exploring the birth experiences of women is important to provide an in-depth understanding of the complex and sometimes contradictory emotions that childbirth may evoke (Larkin et al., 2007). Given the potential for fetal macrosomia to impact on childbirth experiences or outcomes and the limited research available in this area, the aim of this study was to explore women's perceptions and experiences of pregnancy and childbirth following birth of a macrosomic infant.

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## Methods

### Setting and design

Participants were identified from larger cohort of women recruited into a prospective study exploring the impact of physical activity and nutrition on macrosomia (Reid, 2012). The study was conducted in one Health and Social Care Trust in Northern Ireland. The Office for Research Ethics Committee for Northern Ireland (ORECNI) approved the study on 25/06/09 (Ref 09/NIRO2/26). Women gave written informed consent and had at least 48 hours to review the patient information sheet.

### Sample

Women were advised by the researcher during initial recruitment that they may be contacted regarding an optional interview after childbirth. Women were subsequently contacted by telephone at three months post partum, asked if they would like to talk about their birth experiences and given an information sheet explaining the process. If a woman agreed to be interviewed, an appointment was made for the researcher to call at her home. Women who delivered babies  $\geq 4000$  g were selected for interview based on type of childbirth and complications, to provide a balance of experiences within the macrosomic birth weight range. Women invited to participate included those who had a normal childbirth in the Midwifery Led Unit, a normal childbirth in delivery suite, an induction of labour, an instrumental childbirth, an elective caesarean section or an emergency caesarean section, and also included those known to have had problems in previous or present deliveries and those where deliveries appeared straightforward.

### Data collection

Women were interviewed by a member of the research team (ER) in their homes at 13–19 weeks post partum between January and September 2010 about their experience of delivering a macrosomic infant. As a Registered Midwife and Health Visitor, the interviewer was concerned that interviewees may perceive her professional status as a barrier to open, honest responses during the interview. Therefore, a statement was developed which was read out before each interview, reassuring the interviewee of confidentiality and encouraging her to feel free to talk about both positive and negative experiences. One participant knew the interviewer from her professional role. In general, it was believed that the professional status gave the interviewer more credibility, allowing women to delve deeper into their medical experiences rather than hindering disclosure. An interview schedule was developed to ensure that all aspects of women's experiences in the antenatal, intrapartum and postnatal periods were included, previous birth experiences were also explored. As responses may be influenced by the happiness of just having given birth to a healthy infant (Lumley, 1985), interviews were conducted a minimum of three months post partum. Women were encouraged to talk freely about their birth experiences, and about aspects that were important to them. The interview schedule evolved as the study progressed in response to new themes introduced by the interviewees. The schedule was subsequently amended to include questions relating to other's reactions to the size of the infant and perceptions of macrosomia, interviews lasted approximately 45 minutes. Recruitment ended when data saturation was considered complete, with no new themes emerging. Interviews were tape recorded with permission and later transcribed for analysis by a professional transcriber. A copy of the transcript was sent to the

interviewee for verification before analysis and no changes were requested.

### Data analysis

Interviews were analysed using content analysis: a subjective interpretation of the content of the data through a systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon, 2005). Transcripts were read and reread, coded and recurring themes identified. Highlighted sections of text were copied and pasted into Microsoft Word files according to themes. Each file of quotations was then read and subthemes created as they emerged, using the same language as the data. A tree diagram was created to illustrate the relationship between themes and subthemes. At this stage, a sample interview was given to other members of the research team for discussion so that codes and themes could be verified for internal validity. Themes were then integrated, moving to a higher level of analysis by discovering common threads or themes running through the data as advised in the literature (Mayan, 2001). Each of the above steps involved reflection and the sequence was flexible and cyclical until final conclusions were drawn. Analysis was conducted primarily by ER with input from JM, FA and VH regarding the emerging themes.

## Findings

### Response and demographics

Recruitment stopped at 11 women as data saturation had been reached. Only one woman approached during recruitment declined to participate. All the women interviewed were white, married or cohabiting and were of UK/Northern Irish origin. Demographic characteristics and childbirth characteristics of the women interviewed are provided in Table 1.

### Findings

Results are reported according to four key overarching themes, each containing several subthemes (Fig. 1). Quotations from interviewees are used to illustrate themes and subthemes.

**Table 1**  
Demographic and delivery details of women interviewed.

ID number	Birth weight this delivery (g)	Age	Parity	Type of delivery	Previous birth weights (g)
009/005	4840	31	1	El C/S	4400
043/009	4820	29	2	NVD	4200 4200
011/006	4800	30	1	Em C/S	4210
006/002	4780	31	0	Em C/S	n/a
040/010	4680	28	1	NVD	4460
004/001	4650	23	1	Em C/S	3800
028/007	4520	35	2	Em C/S	3850 4570
007/004	4400	32	3	NVD	3450 4000 4450
025/008	4370	29	2	NVD	4150 5000
005/003	4300	32	2	BNF	3700 4210
056/011	4180	36	2	NVD	4350 4900

El C/S: Elective caesarean section, NVD: Normal vaginal delivery, IOL: Induction of labour, Em C/S: Emergency caesarean section, BNF: Barnes Neville Forceps, PPH: Post partum haemorrhage.

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