New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

2021 ŌTAUTAHI Christchurch Conference

Concurrent sessions

16TH BIENNIAL NATIONAL CONFERENCE

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Contents

New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

2021 ŌTAUTAHI Christchurch Conference

Workshops

FRIDAY 05 NOVEMBER

1.30pm - 3.00pm

16TH BIENNIAL
NATIONAL
CONFERENCE
ŌTAUTAHI
2021

MIDWIFE.ORG.NZ/CONFERENCE-2021

W

W1

TUIA Returning the sacred weave into the birthing space

Jacqueline Martin[1]

[1]*Te Whare Wānanga o Awanuiārangi, Whakatāne*

TUIA
Tui, Tui, Tui, Tuia
Tuia i runga
Tuia i raro
Tuia i roto
Tuia i waho
Tuia te taura here muka tangata

The Tui is an iconic bird of Aotearoa New Zealand. Māori traditional methods of storying speak of the Tui who traverses between the spiritual world and the physical world, serving as a messenger of Io, imparting heavenly knowledge to humanity. The song of the Tui is said to resemble the closest voice to Io. When the Tui sings it is an indication Our Ancestors are close by demonstrating the importance of interconnectivity. Returning the sacred weave of birthing into the World of Light.

This Doctoral rangahau gives voice to the revitalisation of Tāpuhitanga – Māori midwifery in the New Zealand context. It explores the question, how are we as midwives, Māori, Pākehā and Tauiwi contributing to the mana and mauri of tangata whenua in the birthing space? Like the Tui, Tāpuhitanga calls forward the teachings of our Atua and our Ancestors to transform the way we engage in the birthing spaces of whakapapa.

W2

The practicalities, the people and the partnership: The National Perinatal Pathology Service

Kay Jones[1], Ainslee Jacobsen[1], Ross Hewitt[1]

[1]National Perinatal Pathology Service, ADHB, Auckland

Background/Introduction: The National Perinatal Pathology Service (NPPS) is the referral point and clinical destination for all perinatal mortality pathological investigations including post mortems and placental investigations in New Zealand. A pivotal point of this service provision is providing information and support to our referrers.

Aim of the workshop: This workshop offers participants a chance to gain insight into the service, the referral process and the potential barriers faced by both referrers and bereaved families/whanau. The activities included in this workshop give participants practical information as well as clear pathways for referral.

Learning outcomes: The participants will be able to:

- Synthesis their current knowledge regarding perinatal pathology investigations with updated information.
- Gain insight into and develop strategies to reduce barriers for both health care professionals and bereaved families/whanau in accessing NPPS.

W3

Midwives in shift-based clinical leadership roles: Associate Charge Midwife Managers (ACMM) / Clinical Midwife Coordinators (CMM)

Claire MacDonald[1]

[1]*New Zealand College of Midwives, Christchurch*

This workshop will provide an opporutnity to discuss the positive impact of the role and network with others from around the country.

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NATIONAL
CONFERENCE
ŌTAUTAHI
2021

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A

A1

Am I a leader? The state of the midwifery leadership in the public hospital setting in New Zealand through the lenses of leader identity, self-efficacy, and shared leadership

Karen Ferraccioli[1]

[1]*Director of midwifery, Hutt Valley DHB*

Background: In 2018, the DHBs depicted a concerning reality describing understaffed maternity units, striving to retain and recruit hospital midwives, and an increase in complexity of service demand. Hospital midwives experience lack of management support and low levels of autonomy, empowerment, professional recognition and satisfaction, development opportunities and access to resources. The midwifery workforce represents only 4% of the clinical staff employed in the DHBs, and report feeling invisible and undervalued.

Objectives: The study aims to describe how hospital midwives perceive their leader identity across the different organizational levels and their view on their ability to succeed in being a leader (self-efficacy). The study will explore to what degree the shared leadership is present within the maternity hospital services and the influence of demographic characteristics and hospital's characteristics on midwives' perception of leadership.

Methods: cross sectional observational study – an on line survey

Results: Will be presented during the presentation. How hospital midwives perceived themselves as leaders (leader identity) and self-efficacy, seems to impact whether leaders emerge. The self-view of themselves as leaders could be a crucial motivational factor driving them into a leadership role, at any level of the organization.

Key message: Adopting a leader identity plays an essential role in leadership. Hospital midwives often do not realize they lead, and they do not identify themselves as leaders, although exercising leadership activities daily. The developing of a strong and ethical workforce may depend on midwives' perception of their role as leaders and their values.

A1

How do midwives and obstetricians communicate at the primary secondary interface?

Rachel Cassie[1], **Christine Griffiths**[2], **George Parker**[2], **Jean Patterson**[2]

[1]*LMC, Hamilton*

[2]*School of Midwifery, Otago Polytechnic, Dunedin*

Interprofessional communication between midwives and obstetricians is important as a critical component of safe maternity care. This qualitative research focused on communication between community based LMC (Lead Maternity Carer) midwives and employed obstetricians/registrars at a New Zealand District Health Board, as part of the requirement for the degree of Master of Midwifery. The objectives were to define effective collaboration from research participants' perspectives, to identify barriers and challenges to good communication, to generate proposals to foster positive collaboration, and to explore participants' understanding and use of the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).

Eight LMC midwives, three obstetricians and two obstetric registrars were interviewed individually about their interactions at the primary secondary interface and their understanding of and use of the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Data was analysed using thematic analysis.

Results indicated usually positive interprofessional interactions. Identified themes were the need to negotiate differing philosophies, to clarify blurred boundaries, and the importance of three-way conversations between midwife, obstetrician/registrar and woman. Effective three-way communication was pivotal in negotiating philosophical difference and clarifying blurred boundaries and usually resulted in ideal communication. The research findings led to recommendations on facilitation of optimal communication.

A1

The midwife as social connector

Lorna Davies[1], **Susan Crowther**[2]

[1]*Ara Institute of Canterbury, Christchurch*

[2]*AUT, Auckland*

No health professional is an island and midwives cannot practice safely and sustainably in isolation any more than any other health professional. In midwifery research, the subject of relationality occurs as an overarching theme within midwifery practice in many different contexts and guises. It is therefore imperative that the value of this social role within midwifery practice is valued and channeled effectively; not left to wane as a result of lack of political will, employment dictates and economic rhetoric. In this presentation we will draw upon the work undertaken for a chapter in a recently published book about sustainability and midwifery practice. We will introduce the concept of social sustainability and consider how this concept could potentially be used to frame midwifery practice and highlight the role of the midwife as social connector. The presentation will unwrap the concept of social sustainability, critiquing the meaning of the terms sociability, social capital and social capacity in order to explain how the midwife in Aotearoa can be viewed as social agent, informed by a unique and contextualised practice. We will additionally demonstrate the alignment of the social connector role with that of the public health aspect of the midwifery role. Finally we highlight ways in which midwifery can and does utilise a socially sustainable approach to practice as well as ways in which this essential component of practice can be enhanced.

A1

The mentoring relationship: Valuing the mentor's role

Shanti Daellenbach[1], Mary Kensington[2] , Lesley Dixon[1], Elaine Gray[1], Christine Griffiths[3], Nicole Pihema[1], Jean Te Huia[4] Dinah Otukolo[5]

[1]*New Zealand College of Midwives, Christchurch*

[2]*Ara Institute of Canterbury*

[3]*Otago Polytechnic*

[4]*Nga Maia Maori Midwives*

[5]*Pasifika Midwives Aotearoa*

Background: Midwifery mentoring is defined as a negotiated partnership between two midwives that provides midwives with professional support. Mentoring has become an important part of midwifery practice in Aotearoa New Zealand, however, little research exists on how mentors understand and experience this relationship. While mentoring provides many benefits to the midwives who are being mentored, the benefits of being a mentor midwife have yet to be fully explored.

Objectives: To examine how mentors understand and experience the mentoring relationship.

Methods: Focus groups were undertaken with midwifery mentors across Aotearoa New Zealand in 2019/2020. These were held in person or via web-conferencing and mentors were invited to discuss mentoring from a general, Māori, Pasifika or rural perspective. Transcripts were analysed using thematic analysis.

Findings: The findings affirm that midwifery mentoring occurs widely in Aotearoa New Zealand both formally and informally. Mentors define mentoring as creating a safe space based on an equal power balance, mutual trust, non-judgement and reciprocity. Being part of a mentoring relationship is personally satisfying and professionally beneficial for mentors, and serves to reinforce their own reflective practice, keep their practice knowledge fresh and nurture their resilience and passion for midwifery. Mentoring relationships in midwifery appear to support professional cohesion and facilitate intergenerational understanding within the profession.

Conclusion: Being part of a mentoring relationship has tangible benefits for mentors and the sustainability of the profession.

Key Message: The findings have relevance for the profession, midwives who are mentors or interested in becoming a mentor.

A2

Minding the gap: Maternal inequity in a wellbeing state

Pauline Dawson[1], Chrys Jaye[1], Robin Gauld[1], Jean Hay-Smith[1]

[1]*University Of Otago, Dunedin*

Background: Aotearoa New Zealand's maternity system offers free maternity care led by midwives. Yet, large maternal health inequities exist with over-representation of Māori and Pacific women in maternal mortality and morbidity statistics.

Objectives: Model associations between social determinants (selected a priori) and poor maternal and perinatal outcomes.

Methods: Using the Statistics New Zealand Integrated Data Infrastructure (IDI), a repository of linked administrative data sets, a composite maternal and perinatal 'poor outcome' variable was derived from maternity data available from 2003-2017 (~900,000 births). Social determinant variables were selected based on World Health Organization Committee for the Social Determinants of Health modelling, including indicators of socio-political context, material circumstances and cultural engagement.

Results: Every social determinant was statistically significantly associated with outcome (all p<.001) Some variables were associated with 3 to 5 times the odds of poor outcome. Other variables were shown to be protective with reduced odds. Notable limitations of the IDI data set are that the variables available tend to be deficit focused and measures of wellbeing are difficult to isolate.

Conclusions: The variables associated with maternal inequity are congruent with associations reported internationally. While a powerful data source, some immediate limitations of the IDI are evident. The administrative nature of the datasets reflects the state's 'power' to determine what is measured; factors that may be important to the wellbeing of women and contribute to maternal health inequity are not necessarily included.

Key Message: Maternal and perinatal outcomes in Aotearoa New Zealand are related to a broad range of social determinants.

A2

Working through complexity: How women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives

Christine Griffiths[1], Judith McAra-Couper[2], Barbara McKenzie-Green[2]

[1]*School of Midwifery, Otago Polytechnic, Dunedin,*

[2]*Auckland University of Technology, Auckland*

In Aotearoa/New Zealand, women living in areas of high socioeconomic deprivation experience significantly higher rates of stillbirth and neonatal death than women living in other areas. A potential contributing factor is access to, and/or engagement with, maternity services.

Constructivist grounded theory methodology was used to explore the research question *'How do women living in areas of high socioeconomic deprivation in New Zealand access and engage with midwives?'*

Women participants were constantly working through complexity as they accessed and engaged with midwives. Women navigated a shifting landscape within the maternity system to find a midwife. Building an effective relationship with the midwife was key to women continuing to access and engage with midwifery care and was a prerequisite for the creation of partnership. Continuity of midwifery care supported this process. Once they accessed a midwife, women relied on midwives to negotiate a pathway through the maternity services with them, wherever that pregnancy pathway led. Importantly study findings demonstrate a maternity system not set up to provide all the resources this group of women require to meet their maternity care requirements, or to accommodate the complexity of their daily lives. Accessing a midwife early in pregnancy, developing an effective relationship with the midwife, and receiving support and advocacy to negotiate a pathway through the maternity system, increases engagement with pregnancy care, and improves a number of pregnancy outcomes for this group of women.

Models of care which we know make a difference to women's engagement with pregnancy care need support and resourcing.

A2

Bearing witness – Midwives' accounts of disadvantaged mothers

Eva Neely[1,2], Briony Raven[2], Lesley Dixon[3], Carol Bartle[3]

[1]Te Herenga Waka, Victoria University of Wellington

[2]Maternity Equity Action, Palmerston North

[3]New Zealand College of Midwives, Christchurch

Maternal disadvantage in the perinatal period is an important predictor of long-term outcomes for women, infants and whānau, including health, education, income, and adverse early life experiences. Widening health disparities are impacting on mothers' wellbeing, as well as affecting the ways in which midwives can deliver quality care. Midwives have insight into women's lives like no other health professional and are exposed to the complexities and layers of disadvantage women face. To understand more about how poverty is experienced by disadvantaged women, Maternity Equity Action (MEA) conducted a survey in partnership with NZCOM to understand how experiences of poverty impact on women and midwives. We conducted an online survey with midwives across Aotearoa that included an open-ended question, enabling stories on the issue to be shared. This yielded 436 responses, with the largest cohort geographically from Auckland (28%) and professionally as LMC midwives (56%). This presentation will discuss the qualitative findings from thematically analyzing midwives' stories. Midwives' insights into disadvantaged women's daily realities revealed just how many layers of disadvantage impact on women in the perinatal period. The stories showed how midwives were often the only health professionals the women still trusted and who were able to support them. Lack of agency was associated with women's gendered poverty and the gaps in the system resulted in an inability to meet many of their complex needs. Implications for advocacy and practice will be discussed.

A2

Community partnership to address inequity

Norma Campbell[1,2]

[1]*Canterbury District Health Board, Christchurch*

[2]*West Coast District Health Board, Greymouth*

The midwifery partnership model is a fundamental and integral part of maternity care in New Zealand since the 1990s.

This model of partnership and how this translates for employed midwives working with LMCs, and in partnership with women to bring their respective knowledge to the woman's journey is not always appreciated or valued. It is a necessary component of our system here in Aotearoa when over 90% of women birth in maternity facilities.

Canterbury DHB have realigned and revitalised their Maternity Strategy. The end product was as a result of strong feedback from both tangata whenua and our wider community. This required the DHB to reconsider how we conducted our processes. We had to really listen to our community and stop making assumptions about what would make the differences needed for our community.

The new strategy is underpinned by a set of values which the DHB Board and the community agreed to in November 2019 and which had to underpin our work together.

The strategy outlines the work programme and priorities and how these were determined to honour the community input . It includes who has oversight of this work and who holds who accountable.

The Canterbury DHB, in partnership with the community has developed a maternity/early years work programme in an endeavour to address inequity.

This presentation will outline the Maternity Strategy and this way of working together which is innovative and at times really challenging.

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B

B1

In good hands: Understanding and affirming LMC midwives' practices of foetal growth assessment

Sheryl Morris[1], **George Parker**[1], **Karen Wakelin**[1]

[1]*Otago Polytechnic, Wellington*

Background: In Aotearoa New Zealand, lead maternity care midwives work in a unique setting, providing continuity of care for women antenatally, intrapartum, and postnatally. This practice ethos benefits both women and their babies by ensuring women are seen regularly by the same midwife, or group of midwives, providing the opportunity to develop a sound understanding of the woman and her pregnancy. An integral aspect of midwifery care is routine antenatal assessment of fetal growth.

Objectives: This research set out to explore the meaning of fetal growth assessment to midwives, and the knowledge, skills, and experience upon which midwives draw to assess fetal growth.

Method: This qualitative descriptive study included semi-structured one to one interviews with fourteen LMC midwives that were thematically analysed.

Results: How midwives feel about assessing foetal growth, the marginalisation of midwifery knowledge, and a growing reliance on technological tools were the key themes that emerged from the data.

Conclusion: Fetal growth assessment is an important midwifery skill which combines scientific, holistic, experiential, and intuitive knowledge. Midwives generally have confidence in their ability to assess fetal growth accurately, although the increasing medicalisation of the maternity landscape and growing reliance on technology is changing not only how the midwifery assessment is viewed, but also how midwives feel about this.

Key Message: Midwives are skilled practitioners, and in Aotearoa New Zealand's continuity of care context, are well placed to assess foetal growth.

B1

Personal use of hand-held fetal heart rate doppler monitors by pregnant women in New Zealand

Lyndal Honeyman[1], **Robyn Maude**[1]

[1]*Victoria University of Wellington, Wellington*

Background: Devices for listening to the fetal heart rate during pregnancy, such as the hand-held Doppler, are now more widely available to the general public via the internet. There is very little research into the use of these technologies by pregnant women, but general consensus by childbirth professionals is that women should be discouraged from use due to the risk of delaying seeking assistance from false reassurance that these devices could potentially provide to non-health professionals. Despite this warning, women do access these devices for their personal use during their pregnancy.

Objectives: This qualitative descriptive study aimed to discover reasons women had for using personal fetal heart rate monitoring devices, and their experiences of using them. Ethics approval was granted by the Victoria University of Wellington Human Ethics Committee.

Methods: Participants were recruited via social media, and community-based lead maternity care midwives. Participants were interviewed using a semi-structured interview schedule, and the data was thematically analysed.

Results: Women who access fetal heart rate monitoring devices use them as a way of managing their anxieties around pregnancy, as well as a way of taking charge of their own health and wellbeing. They source support and information via social media, with peer-developed content supporting their decision making. Professional supports from midwives vary, with women wanting greater guidance from their midwife.

Conclusions and Key Messsage: More research into the use of fetal monitoring technology by pregnant women is needed, especially for midwives and how they can best support women who choose to use the device.

B1

The paradox of contemporary midwifery practice: Promoting an out-of-hospital birth setting

Bronwyn Torrance[1], Joan Skinner[2], Robyn Maude[3]

[1]*Lincoln Hospital, Canterbury District Health Board, Christchurch*

[2]*School of Nursing, Midwifery, and Health Practice, Faculty of Health, Victoria University of Wellington, Wellington*

[3]*School of Nursing, Midwifery, and Health Practice, Faculty of Health, Victoria University of Wellington, Wellington,*

In New Zealand most women choose their place of birth in partnership with their midwife. Despite having a robust model of midwifery-led care, free access to primary maternity units, and clear evidence indicating healthy women should birth out-of-hospital, most women still choose to birth in hospital. This qualitative descriptive study concerns itself with this dilemma.

As the study aimed to focus on the successes of an approach, an Appreciative Inquiry lens was used. Appreciative Inquiry enabled a re-framing of the research problem to a strength-based approach, to examine achievement rather than failure. Consequently, the research questions 'How do midwives with a high primary unit caseload, discuss place of birth with the women they care for?'

Methods included four focus groups and thematic analysis. Applying inductive and deductive reasoning, five themes emerged: *Ways of knowing: woman, art, science and research; Trusting in you, me, and the process of childbirth; Setting boundaries as a 'primary birth midwife'; and Delaying and diverting, a malleable approach, centered around the theme When it matters what we say: reframing safety and risk.*

Alongside supporting current research, this study adds to the body of knowledge about birthplace choice by bringing to the fore the notion of paradox in practice, setting boundaries whilst remaining malleable for example. In a contemporary maternity context, these midwives dance between two worlds fundamentally at odds with one another, effectively managing contradiction, complexity and uncertainty to achieve a high primary unit caseload.

B1

Do we need post birth care plans when there is continuity of midwifery carer? Insights from a UK based study

Susan Crowther[1,2]

[1]*AUT University, Auckland*

[2]*Robert Gordon University, Aberdeen, Scotland*

Background: Post birth care continues to cause sub-optimal satisfaction for women and families globally. Evaluation of post-birth care to improve satisfaction is urgently needed.

Objectives: To develop and evaluate an acceptable and useable template for post-birth care planning (PBCP) through collaboration with women and community midwives in Scotland.

Methods: Qualitative methodology using an action research design. 10 pregnant women were interviewed twice (antenatally and postnatally) and 6 community midwives across two focus groups.

Results: Through consensus seven themes emerged informing a PBCP template: 'being prepared for transitions', 'physical needs', 'psychosocial needs', 'cultural, religious and spiritual needs', 'organisation of care information', 'knowledge transfer', 'financial information and guidance'.

Conclusion: Participants recognised the benefit of using a PBCP to encourage individualised care that could be organised according to cultural, social and physical needs using an open conversational style that explored needs as they developed over time. The desire for individualised personalised planning was welcomed to counteract local fragmentation of services.

Key message: Although New Zealand midwifery is based on relationships, there is valuable learning provided from this study affording opportunity to explore post birth care planning from different perspectives. Working in increasingly diverse communities' women require time to explore their post-birth in meaningful and respectful conversations that honour their unique and changing needs. PBCPs have potential to improve women's satisfaction especially in regions where fragmentary systems of care are prevalent. What remains unknown is whether PBCPs would offer improvement in New Zealand's model of care, specifically for women with complex social-cultural, spiritual-emotional and physical needs.

B2

Continuity of midwifery care in complexity: A qualitative description

Eleanor Martin[1]

[1]*Victoria University Wellington, Wellington*

Background: Continuity of midwifery care has demonstrated some beneficial outcomes for low risk mothers and their babies with no evidence of poorer outcomes. The model of midwifery in New Zealand, is based on partnership with continuity of midwifery care. When the woman or her baby is experiencing significant complications continuity of midwifery care is enabled through the guidelines for consultation and referral. This care would be provided in collaboration with and support from medical personnel and hospital-based midwives. There is no research that has specifically examined the outcomes for women with complex needs. This research explores how women with complex needs and who have had continuity of midwifery care have experienced this care.

Aim: The aim of this research was to provide a comprehensive description of how women with complexities experience continuity of midwifery care across the maternity episode.

Methods: A qualitative descriptive study was conducted in one region of New Zealand. Three women, all with varying types of complexity were interviewed. The interviews were transcribed, and the transcripts were analysed thematically.

Results: There were four themes: the relationship was everything; knowing what was happening was important; power was managed and balanced; and extra care was needed.

Conclusion: The three women had the same needs and experiences of continuity as did low risk women. However, another aspect, not previously reported, was that the women thought that the midwives spent a lot more time with them than they otherwise would have needed to.

Key messages: Continuity is even more important when complexity increases. The woman defines the complexity; the midwife becomes the central holder of that interpretation.

B2

Continuity of care: An analysis of care providers' outlook on women's experiences of unplanned/emergency caesarean section within New Zealand maternity system

Charles Egwuba[1], Annabel Ahuriri-Driscoll[1], Sarah Lovell[1]

[1]*University of Canterbury, Christchurch*

In NZ, normal birth has been at the core of the maternity philosophy, particularly among midwives. The midwifery model is centred on providing continuity of care during pregnancy, birth and up to six weeks postnatally. Women who experience continuity of care report greater satisfaction with their maternity provider. Yet, unplanned and emergency caesarean section complicates a woman's care journey as the midwife transfers care to a hospital-based obstetric specialist in what is often unanticipated and difficult circumstances. CS rates continue to rise globally, current rate in NZ is estimated at 25-30%. Women who undergo CS commonly report increased negative birth experiences, specifically, longer maternal recovery periods, lower rates of breastfeeding and increased risk of post-traumatic stress disorder. This qualitative study was conducted to explore LMCs accounts of the nature of care for women during and after unplanned/emergency CS. In-depth interviews were conducted with 11 LMCs (seven midwives and four obstetricians) practicing in Canterbury. Participants were recruited purposively, interviews transcribed verbatim and data analysed using Framework approach described by Ritchie and Spencer. Three main themes emerged through the data analysis: (1) "It makes a really big difference": Achieving a woman-centred maternity system through continuity of care, (2) 'Midwifery philosophy of normal birth shaping the culture of care', and (3) "End of story! We have a huge amount of power": Influencing women's decision-making. The results of this study contrast with international literature by demonstrating that a midwife-led LMC model can support a culture of responsive care among both obstetricians and midwives.

B2

Doing time: The experience for women hospitalised for an extended time in their pregnancy

Michele Lomax[1]

[1]*AUT, Manukau*

Background: Pregnancy and childbirth are a normal physiological process. For some women this is not the case if they experience complications, which require hospitalisation for long periods during their pregnancy. Hospitalisation during pregnancy can lead to negative physiological effects, such as anxiety and depression, which can extend into the postpartum period.

Objective: To gain meaningful insight into the lived experiences of women hospitalised for an extended time in their pregnancy. This research asked the question "What is the experience for women hospitalised for an extended time in pregnancy?"

Method: Using hermeneutic phenomenology this study explored women's lived experiences of being hospitalized for an extended time during pregnancy. In-depth face to face interviews were conducted with seven women who had been hospitalized for two to twelve weeks during their pregnancy. Rich, extensive data emerged and van Manen's existential's (lived time, lived body, lived space, lived relationality) was used to structure the analysis.

Results: Four main themes emerged from this study, which included feeling displaced, feeling unsafe in hospital, feeling imprisoned, and coming out the other side.

Key message: The lack of continuity with health professionals and conflicting information led to the women distrusting some of the information and made their stay feel unsafe. These women felt trapped in an unfamiliar and restrictive environment. In an effort to ensure women who are hospitalised in their pregnancy feel safer and comfortable, more able to make informed decisions about their care, midwives and other health professionals need to be more aware of the negative impact extended hospitalisation has on some women.

B2

Water immersion in complex pregnancy

Kelly Kara[1], **Suzanne Miller**[2]

[1]*Ara Institute Of Canterbury, Christchurch*

[2]*Otago Polytechnic, Dunedin*

Background: Low-risk women who have used water immersion in labour express feelings of increased relaxation, support and control. Being labelled 'high risk' can significantly impact woman's experience of her pregnancy with a feeling that her normal childbearing journey has been subsumed by monitoring and risk management. Water immersion for women with complexity often sits outside recommendations and guidelines.

Objectives: This research aims to develop an understanding of the influences, facilitators and barriers for women who chose to use water immersion for labour and birth during a complex pregnancy, as well as to explore their lived experience of using water immersion in labour.

Methods: A qualitative descriptive approach, using semi-structured interviews explored women's experiences. Inductive thematic analysis was used to analyse participant data. The Midwifery Research and Ethics Committee at Otago Polytechnic granted ethics approval for this project.

Results: Women with complex pregnancies want to make informed choices to use water immersion in labour. This is often related to resisting the medicalisation of their birth based upon their previous experiences. A strong partnership with their LMC is valued in empowering women to negotiate this choice within the hospital system.

Conclusions: Women use water immersion in labour to optimise their opportunity for physiological birthing, often in response to previous experiences and the partnership with their LMC midwife is key in supporting this decision making.

Key message: Women value making informed choices about using water immersion during a complex pregnancy and the LMC midwifery partnership is key in supporting this process.

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2021 ŌTAUTAHI Christchurch Conference

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SATURDAY 06 NOVEMBER

11.00am - 12.30pm

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W

W4

The influence of history on contemporary issues for hospital midwives

Caroline Conroy[1], Jill Ovens[1]

[1]MERAS, Christchurch

The issues facing midwives today include midwifery shortages, concerns about pay rates, the challenges of getting midwifery recognised as a profession separate from nursing within the DHBs and Ministry of Health and the way midwifery is portrayed in the media.

The place of women in society, the value placed on women's work, the challenges that midwifery has faced since the early 1900's and various legislative changes have all impacted on the contemporary issues facing midwifery today.

There is a saying that 'we need to remember our history so that we don't repeat it'. There is now a generation of midwives born since the Nurses Amendment Act 30 years ago and it would be all too easy to forget the challenges that midwives have faced in the last 100 years as we try to navigate our way through the challenges of today.

This workshop explores how the contemporary issues facing New Zealand hospital midwives today have been influenced by history and the opportunities we have to shape and create our future.

What place will the Midwifery Pay Equity claim, the Midwifery Accord, Care Capacity Demand Management and the work to better define midwifery career pathways and strengthen Midwifery Leadership have in addressing the issues facing Midwifery today and defining our future history.

This is an interactive workshop that will provide opportunities for midwives to relate the history, workplace culture and challenges in their own workplaces to the broader context of history and contemporary issues facing midwifery today. How are these issues being addressed locally?

Reflecting on the themes of the International Year of the Midwife how best do we *Celebrate* our successes as hospital midwives, Demonstrate the impact of investing in hospital midwifery, *Mobilise* to advocate for midwifery and Unite with one voice as hospital and community midwives.

W5

Tools for undertaking perinatal mental health assessment, support and referral

Clare Barnett[1]

[1]*Registered Midwife, RCompNurse*

[1]*Whitehead, K. & Barnett, C. (2018). The Edinburgh postnatal depression scale. In L. Bredenkamp (Ed.), "Are you Ok?...Really? A resource about perinatal mental health for care providers", (pp 41-50). Wellington, New Zealand: PADA*

Learning outcomes: To share learning around how midwives currently undertake perinatal mental health assessment, including history taking and clinical signs of perinatal distress. To introduce screening tools, particularly how to use the Edinburgh Postnatal Depression Scale (EPDS), both manually and electronically; including suicide risk assessment. To stimulate discussion and networking around resources available for women to use in the community and how to undertake formal perinatal mental health referral.

Process activity: Large group power point presentation on research around perinatal mental health screening and statistics, PMMRC findings, clinical symptoms and use of EPDS. Individual reflection, work in pairs, small group discussion and 'hands-on' practice activities regarding midwife experiences around perinatal mental health, how to use the EPDS, community resources, suicide risk, and making a referral.

W6

Spirituality and childbirth: A co-operative inquiry

Susan Crowther[1,2]

[1]*AUT University, Auckland*

[2]*Robert Gordon University, Aberdeen, Scotland*

Background/Introduction: Those involved in childbirth have spiritual experiences, therefore any discussion on childbirth is incomplete without inclusion of evidence in this field and may-be unsafe for women and unsustainable for practitioners. However, such evidence has been slow to emerge because spirituality is often viewed as lacking in substance, being subjective and difficult to study; especially when concerned with childbirth. This workshop will share different aspects of learning from a novel form of participatory action research called co-operative inquiry (CI) that enables development of an in-depth appreciation of the experiences of spirituality around childbirth.

Aim of the workshop: CI is more than a collaborative project; it incorporates both reflective and transformative elements. The workshop will be innovative and exploratory honouring diversity and appreciation of myriad cosmological worldviews and encourage and encourage participants to turn inquiry reflections into transformative practice-based actions. The aim is to take participants on a group journey of thinking where they can contribute their own experiences and ideas.

Learning outcomes:

- To reflect on the outcomes of an international co-operative inquiry into spirituality and childbirth
- To consider how concealing spirituality around childbirth causes unsafe practice and lead to poorer outcomes
- To re-evaluate and consider the significance of spirituality around childbirth within individual and collective midwifery practice
- To discover ways to articulate qualities of spirituality around childbirth.

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C

C1

What factors enabled Pasifika midwives to successfully complete their undergraduate degree?

Talei Cummins[1], **Karen Wakelin**[1], **George Parker**[1]

[1]*Otago Polytechnic, Dunedin*

Background: Despite there being a large, and increasing, Pacific birthing population, Pasifika midwives are a minority within Aotearoa's midwifery workforce. Numbers of Pasifika students entering and completing midwifery education are low. There is a need to attract, educate and retain more Pasifika midwives to work with Pasifika women.

Objectives: To investigate sources of support that enabled Pasifika midwives in Aotearoa to successfully complete their undergraduate degree.

Methods: A qualitative approach, informed by the Pacific Talanoa Research Methodology (TRM), was used to investigate enablers for Pasifika midwifery student success. TRM was culturally appropriate, with all ten participants identified as Pasifika. Face-to-face talanoa were conducted with midwives who qualified in Aotearoa within the last six years. Interview data were transcribed and coded using thematic analysis.

Results: For Pasifika midwifery students, family support was paramount for success. Belonging to the Pasifika midwifery community, including the 'Aunties Initiative', and sistership with other midwifery students, was another important enabler. Pasifika midwifery students found support and advocacy from academic staff invaluable, especially Pasifika staff where available. They also appreciated scholarships and subsidies that relieved some of the financial pressure they faced as students.

Conclusion: Pasifika midwifery students benefit from the support of family, the Pasifika midwifery community, including students and staff at their educational institutions, and financial assistance on their journeys to becoming midwives.

C1

The use of virtual reality as a teaching modality in midwifery education

Melanie Welfare[1]

[1]*Ara Institute Of Canterbury, Christchurch*

Midwives have to 'demonstrate competency in the practice of midwifery following the completion of a recognised programme of education. This includes the promotion of physiological birth and the management of emergency situations for the woman and the baby'. The ability to gain this experience is often dependent on the situations that the student is exposed to throughout their midwifery programme of education. In emergencies, a student's learning can become secondary to the mother or baby's safety. Over the past two years a multi-disciplinary team from Ara Institute of Canterbury have developed a virtual reality (VR) physiological birthing woman. The purpose of this project was to provide additional experiential learning opportunities for both midwifery and nursing students within Ara. VR is now being included in all three years of the midwifery education programme at Ara Institute of Canterbury. The use of spatial computing to interact with a virtual reality (VR) birthing woman provides midwifery students with opportunities to practice, make and rectify mistakes and develop their decision-making skills in a safe and interactive setting which should lead to increased confidence in real world situations.

This presentation will focus on the research supporting the use of spatial computing as a education tool, the collaboration between the multi-disciplinary teams involved in this project, the challenges and highlights of the software development and the initial experiences of the students and staff members who have interacted with the VR.

C1

Prebrief or debrief? Using simulation in collaborative midwifery and medical education

Rea Daellenbach[1], Lorna Davies[1], Maggie Meeks[2], Judy Ormandy[3], Melanie Welfare[1]

[1]Ara Institute of Canterbury, Christchurch

[2]Canterbury and West Coast District Health Board, Christchurch

[3]Otago University School of Medicine, Christchurch

When medical staff and midwives communicate effectively, obstetric outcomes improve. In emergency situations where health personnel take on shared responsibility for the wellbeing of those involved, this is especially so.

An action research study designed by a team of midwifery and medical educators in Christchurch set out to explore how collaborative, interprofessional learning introduced at undergraduate level could be structured to enhance professional interaction and team work at this emergent stage in the development of future health professionals. The project has ethical approval from the Ara Ethics Committee.

In the first cycle of the study, students reflected on the simulation undertaken and identified that 'pre-briefing' would have been as useful as 'debriefing' in terms of their learning and particularly their levels of confidence in approaching the set-up. Debriefing in simulation is viewed as an integral and essential component. Yet prebriefing, which involves orientation prior to the simulation is less visible in the literature although defined in some contexts as best practice.

Our project has identified that enabling students to have constructive discussions between each other about their roles and expectations of each other both before and after the simulation enhances the quality of the learning for them. This may be specific to midwifery and medical students in New Zealand, reflecting their scopes and the collaborative interface of their interprofessional relationships.

C1

Just relax! But how?

Carrie Cornsweet Barber[1]

[1]*University of Waikato School of Psychology, Hamilton*

Background: Relaxation allows the body to care for itself and connect in healthy ways with others. When we feel safe and relaxed, we can heal from hurts and prepare for what comes next. This is something we all need—pregnant and birthing women, new mothers, and the people who care for them—midwives and whānau. However, this is also something many of us struggle with—finding the time and the way to let go of stress and allow the body and mind to rest.

Purpose: Relaxation has been shown to be effective in enhancing maternal wellbeing, delaying preterm labour, and improving new-born health. t's also important for midwives to explore and find their own best methods for self-care to remain healthy and strong to support whānau.

Project: This presentation will describe some methods of relaxation, summarise data from a study of what pregnant women say works for them to manage stress and relax, present initial findings comparing guided meditation and flotation-REST with pregnant women, and talk about how midwives can help parents to find what works for them.

Discussion: As we guide and support others to care for themselves in order to care for their baby, we are reminded of how we must care for ourselves in order to care for our clients. These methods and messages are for all of us. The methods will vary, depending on culture, personality, and context, but the message is the same: relax.

Key Message: Relaxation is not a luxury—it's a responsibility.

C2

Management of prolonged prelabour rupture of membranes at term: Findings and discussion from a clinical notes review

Rebecca Hay[1,2], Robyn Maude[2], Susan Calvert[2,3]

[1]*Liggins Institute of the University of Auckland*

[2]*School of Nursing, Midwifery and Health Practice, Victoria University of Wellington*

[3]*Midwifery Council of New Zealand*

Background: Practice guidance within DHBs is somewhat consistent for women with prelabour rupture of membranes at term, however one DHB provides a 96-hour period of expectant management for women who otherwise have no known risk factors for Group β streptococcus transmission to their neonate.

Objectives: This project asked whether the longer period of expectant management serves the needs of women and babies in this DHB, without increasing risks for either.

Methods: A retrospective clinical notes review was conducted of files belonging to women who had duration from ROM to birth of 18 hours or more (n= 123; range 18:00 to 204:25 hours). Comparisons were made with overall outcome data at the DHB, and with wider population data from the College of Midwives Clinical Outcomes Research Database.

Results: Key outcomes to be presented include comparisons of key outcomes for women birthing more than 18 hours after ROM, based on: Māori vs non-Māori ethnicity; maternal smoking; maternal engagement with care following ROM; increasing duration from ROM to birth; intrapartum oxytocin use; use of artificial rupture of membranes; outcomes for babies who are small for gestational age; and overall PROM outcomes.

Conclusion: Women birthing following PROM of greater than 18 hours had increased rates of labour induction, augmentation, epidural use, operative births, postpartum haemorrhage, neonatal admission to Special Care Baby Units and decreased exclusive breastfeeding at discharge; however the causes of unfavourable outcomes were multifactorial and duration of expectant management did not appear to influence risk.

Key message: Recommendations for clinical management of PROM have become increasingly risk-averse; however this research provides a comparison which is useful for informed clinical practice and decision-making.

C2

Midwives are key in recognising neonatal encephalopathy: Do you know what to look for?

Julie Richards[1], **Robin Cronin**[1]

[1]*Midwife representatives on the Neonatal Encephalopathy working group, Wellington*

Neonatal Encephalopathy (NE) is a complex syndrome of neurological dysfunction in the newborn leading to mortality when severe and neurodevelopmental disability when moderate. NE occurs in 1.4 per 1000 live births in New Zealand. It is clinically defined following birth by difficulty initiating and maintaining respiration, depression of tone and reflexes, altered levels of consciousness and often with seizures. When this occurs as a result of a hypoxic perinatal event, the only available treatment is therapeutic hypothermia or whole body cooling, which is required to be commenced within 6 hours of birth to be effective. Therefore early recognition, documentation and referral or transfer to neonatal services are essential to improve outcomes for affected newborns.

NE is an umbrella term used in preference to hypoxic ischaemic encephalopathy because it is now recognised that various antenatal and perinatal causes exist, often in combination. Acute perinatal events resulting in hypoxic ischaemia are present in 25% of cases with other causes including infection, placental abnormalities, metabolic disorders and genetic abnormalities. This can make recognition of NE more challenging in order to make a timely referral of the baby and commence therapeutic cooling within the 6 hours 'window of opportunity'.

Midwives are well placed to recognise the signs of NE as the practitioner present with wāhine, pēpi and whānau following birth. The newborn early warning score and observation chart support this assessment as well as the Simplified Sarnat Criteria, a specific tool to assess NE, when predisposing events or risk factors are present.

Understanding the causes of NE alongside ongoing assessment and documentation in the immediate postnatal period will increase the recognition of NE and enable early referral. This has the potential to reduce morbidity and mortality for up to 25% of babies affected by NE.

C2

A conservative approach to deformational plagiocephaly

Patel Dipal[1]

[1]*The Connection, Auckland*

Background: Deformational Plagiocephaly has now become a very common craniofacial problem in infants. Many parents seek additional care and resources to help prevent, improve and resolve this issue. One of the most common reasons for cranial specific care to be sought from a healthcare provider is to help with Deformational Plagiocephaly. Holistic Chiropractic care on the cranial-dural system can serve as a useful conservative approach to assist the resolution of Deformational Plagiocephaly.

Focus of the discussion: Deformational Plagiocephly results from repeated external pressure on an infant's skull, often due to head positioning. When viewed from above, the shape of the skull appears flattened posteriorly, most commonly through the occiput. There may also be noticeable asymmetry of the facial structures in association with the flattening of the posterior skull. Since the introduction of the "Back to Sleep" campaign in 1992, there has been a significant increase in the incidence of Deformational Plagiocephaly. Other causes include muscular torticollis, prematurity, in utero constraint and birth trauma.

Due to the increased prevalence we will discuss the early interventions which can help to prevent, improve and resolve Deformational Plagiocephaly. These interventions will include preventative measures which will enable parents and caregivers to play an active role in supporting their child's growth and development.

Implications: Apart from the cosmetic implication of the appearance of the head, it is important to acknowledge the possible neurological impact of Deformational Plagiocephaly.

There is a growing body of evidence to suggest an association with an increased risk in neurodevelopmental delay. Studies have shown both cognitive and motor developmental delay in those with Deformational Plagiocepahly.

Due to the increasing growth of the cranium in the first 12 months, prevention and early intervention are key to avoiding long term effects.

C2

The voice of women - Women's perspective of their midwifery care through a Midwifery Quality Assurance program

Jacqui Anderson[1], Lesley Dixon[1], Sarah Lockwood[2], Shanti Daellenbach[1], Ariana Nisa-Waller[3], Eva Neely[4]

[1]*New Zealand College of Midwives*

[2]*Lockwood Research and Consultancy*

[3]*University of Otago*

[4]*Victoria University of Wellington*

Background: Getting feedback about their midwifery care is an important aspect of reflective practice for midwives and is supported by the New Zealand College of Midwives (the College) through a formal on line feedback process. The College receives thousands of feedback forms from women about their midwifery care each year. The feedback is anonymous and is used by the midwife as part of her Midwifery Standards Review (MSR). The feedback questions are based on the Midwifery Standards for Practice and provide the midwife with essential information on how her care is perceived by women and assists reflection on her practice.

Objective: To identify, through the feedback forms, the characteristics of midwifery care that women describe as having had a positive or negative effect on their experience.

Methods: A retrospective analysis of the data in the consumer feedback forms has been undertaken for one calendar year (2019). The consumer feedback form has eleven statements related to midwifery care. Each statement has a five level Likert scale of agree/disagree and an opportunity to provide an open text response. At the end of the form there is an opportunity for the woman to provide extended feedback or comment. Quantitative analysis of the Likert scales has been undertaken along with thematic analysis of the open text feedback.

Results: The vast majority of feedback from women identifies positive perceptions of their midwifery care and a small proportion of feedback identified negative perceptions. Early themes identified are; building trust, increased personal confidence, honouring decisions and a valued relationship. Negative perceptions were related to a lack of trust and confidence resulting in disempowerment.

Conclusions: Women's feedback is a rich source of data about how women perceive their midwifery care

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D

D1

Vaginal seeding – The ECOBABe study and latest international findings

Celia Grigg[1], Éadaoin Butler[1], Brooke Wilson[1], José Derraik[1], Justin O'Sullivan[1], Nick Walker[1], Wayne Cutfield[1]

[1]Liggins Institute, University of Auckland, Auckland

Introduction/Background: Vaginal seeding is the process of transferring maternal bacteria to babies born by caesarean section, to try and mimic the normal physiological process occurring during vaginal birth. The concept was introduced in the Microbirth Movie, which led to its use informally here and elsewhere. It generates diverse reactions from practitioners and women alike. The ECOBABe (Early Colonisation with Bacteria After Birth) study in Tāmaki Makaurau Auckland was primarily a pilot Randomised Controlled Trial, and also a mixed methods study of women's views of vaginal seeding.

Purpose: The gut microbiome is important in human development and health. The concept of vaginal seeding makes sense physiologically and, it's important to find out if it works, and learn a little about the knowledge and beliefs of pregnant women.

Project: I will present the findings of the ECOBABe studies, and briefly outline the current international evidence surrounding vaginal seeding.

Discussion: The aim is to provide an evaluation of what's currently known and not yet known, to inform midwives practice and their conversations with women/whānau, on this fascinating topic.

Key message: The normal physiology of birth, and early life influences on long-term wellbeing, is central to midwifery. Vaginal seeding is a concept which makes sense, but is in need of evidence for its efficacy and safety. Midwives need contemporary knowledge to inform their practice and their conversations with women/whanau.

D1

Timing of cord clamping (TOCC): An observational study of cord clamping practice in a New Zealand maternity hospital

Tina Hewitt[1]

[1]*Otago Polytechnic, Christchurch*

Background: When an umbilical cord is left unclamped after birth, a significant proportion of the blood from the placenta will flow into the newborn, contributing to approximately one-quarter of total potential blood volume. Longer cord clamping times increase infant iron stores and allow a more stable transition to extra-uterine life.

Objective: The study investigated cord clamping practice in New Zealand in light of the growing evidence for improved neonatal outcome with longer placental transfusion times.

Methods: A stopwatch was used to time the cord clamping interval for 55 term vaginal births in a tertiary maternity hospital. Descriptive statistics were used to analyse cord clamping times against mode of birth, maternal position for birth and healthcare practitioners involved in the birth.

Results: The median umbilical cord clamping time was 3.5 minutes and was likely to be longer when the woman had a spontaneous birth; when she birthed in a side-lying position; when a midwife facilitated the birth and when there was no neonatal team present at the birth.

Conclusions: The median cord clamping time of 3.5 minutes indicates a shift away from the practice of immediate clamping. Further discussion is warranted on how longer cord clamping times fit with active management of placental birth and how we can achieve optimal cord clamping when newborn resuscitation is indicated.

Key Message: Early cord clamping is an intervention that must only be used when there is clear evidence that it will add benefit and avoid harm.

D1

A heavy heart and a pocket full of grief: An interpretive inquiry of midwives' first experiences of stillbirth as a community based midwife

Kay Jones[1]

[1]*AUT, Auckland*

Background: This study looks at the potential impact on midwives caring, for the first time, for women experiencing stillbirth. Acknowledgement and understanding of the lived experiences of midwives is critical for sustainability of the midwifery profession.

Objectives: This research strives to recognise that the death of a baby is a significant event for the midwife providing care to a family/whanau who experience a stillbirth. It investigates the potential impact on midwives by hearing and interpreting their stories.

> *'What is the lived experience of midwives the first time they care for a woman having a stillbirth?'*

Methods: An interpretive phenomenological study using semi-structured interviews. Five community based midwives were interviewed and asked about their experience. Data from these interviews was analysed using van Manen's framework.

Results:
First theme - 'Pocket Full of Grief' with three sub-themes:

- Shockwave
- Denial + Invisibility = self-protection
- Blameworthiness

Second theme - 'A Heavy Heart' with three sub-themes:

- Touched by Death
- Empathetic Loss
- Broken.

Conclusion: The midwife steers her way between providing situation sensitive care to the woman and her family and coping with her own intense and overwhelming feelings that are often hidden and not spoken of. These midwives experienced something that changed them and their midwifery practice, forever. Individually each midwife gained practice wisdom that cannot be taught or scripted.

Key Message:
Caring for a family experiencing a stillbirth is a pivotal point in the midwives' practice Recognition of this is vital to the sustainability of the midwife and the midwifery profession.

D1

The observational study of current practice of postpartum anaemia

Esther Calje[1], Katie Groom[1,2], Frank Bloomfield[1], Charlotte Oyston[3,4], Joy Marriott[3,5], Lesley Dixon[6]

[1]Liggins Institute, University of Auckland, Auckland

[2]National Women's Health, Auckland Hospital, Auckland

[3]Department of Obstetrics and Gynaecology, University of Auckland, Auckland

[4]Department of Obstetrics and Gynaecology, Middlemore Hospital, Auckland

[5]Department of Obstetrics and Gynaecology, Waikato Hospital, Hamilton

[6]New Zealand College of Midwives, Christchurch

Background: Postpartum anaemia is not only associated with morbidity and mortality, but also fatigue, depression, impaired cognition, reduced breastfeeding, impaired bonding, and infant developmental delays. Blood transfusion has been the standard treatment for severe postpartum anaemia, but recently intravenous (IV) iron has been introduced as an alternative. The safety and effectiveness of IV iron compared to blood transfusion for non-acute postpartum anaemia is unclear.

Objectives: The primary objective is to quantify the number of women with postpartum anaemia (Hb<100 g/L) and describe the treatment they receive: blood transfusion, IV iron, oral iron, a combination of treatments or no treatment.

Secondary Objectives are to: quantify severe anaemia (Hb<85 g/L); compare rates of postpartum anaemia and management by region and ethnicity; compare current practice to recommended practice; describe reported adverse reactions; describe follow-up practice and measure differences between Hb and ferritin levels pre/post treatment.

Methods: This is a retrospective observational study of all cases of postpartum anaemia (Hb<100 g/L) at Canterbury, Counties Manukau and Waikato District Health Boards over a six-month period. Data collected includes maternal demographics, pregnancy and labour details, antenatal anaemia, use of iron and/or blood transfusion, adverse reactions and follow-up after treatment. Practice will be compared to local and national guidelines.

Results: Preliminary results will be presented

Conclusions: This study begins to address an evidence-gap in current practice. It will inform the FIT Trial to guide future best practice assessing the most meaningful outcomes for mothers and babies.

Key Message: This study will support more consistent care across Aotearoa.

D2

Transgender pregnancy in Aotearoa New Zealand - A first-hand experience

Scout Barbour-Evans[1], Fiona Heares[2]

[1]Independent Researcher, Dunedin

[2]Independent LMC, Dunedin

Scout chose their midwife before they'd even conceived their child. They are takatāpui, or transgender, and they needed to make sure they chose a midwife who would be open-minded enough to do a lot of learning on the way. Insert Fiona, a Dunedin midwife who came highly recommended as an open-minded midwife always keen to develop her practice and learn new and exciting things.

At the time of Scout's pregnancy there were no research papers published in New Zealand about transgender pregnancy, there were no health resources that included transgender people, and many transmasculine people in Aotearoa New Zealand didn't know they were able to conceive a child. Scout even had to lie that they were a woman in the Ministry of Health paperwork to be under Fiona's care.

In this presentation, Scout will discuss the health resource on transgender pregnancy that they have since created, and Fiona will discuss her experience as Scout's midwife and how she worked to affirm Scout's gender in her practice. While the midwifery profession should always centre women in it's work, Scout and Fiona are calling for additional models of practice to be employed when working with transgender New Zealanders, so that nobody has to leave who they are at the clinic door.

D2

Migrant Kiribati women and birth in New Zealand

Kathy Carter[1]

[1]*Self Employed MW/AUT, Warkworth*

Introduction/Background: Kiribati is a group of atolls in the Pacific which is threatened by climate change and is one of the poorest countries in the world. I-Kiribati (Kiribati people) are among the increasing number of migrants entering NZ.

Purpose: Several times in recent years, I found that a third of my caseload were I-Kiribati. If these women had complications, it appeared they were more serious than those experienced by others, and intercultural misunderstandings had potential to negatively influence their care. NZ health statistics show Pacific Islanders are more likely than most New Zealanders to have poor outcomes in the perinatal period along with other health inequities. I-Kiribati are included in these statistics but are not differentiated. Little is written about I-Kiribati health.

Project: I wanted to understand more than statistics, so I chose to listen closely to Kiribati women's stories, gifted to me, about their experience of childbirth in NZ. Several stories are presented, along with my reflections.

Discussion: Several themes are emerging from the stories. Women faced with tensions as migrants "between" two worlds. Assumptions being made by midwives that were not how it was for the woman. Building trust is key to establishing an effective relationship.

Key message: When midwives work with individuals of cultures different to our own, there is so much 'not yet understood' by either party.

D2

Evaluation of the 'Sleep on Side' NZ public health awareness campaign

Robin Cronin[1]

[1]*University of Auckland, Auckland*

Background: The 2018 NZ 'Sleep-On-Side When Baby's Inside' public health campaign was initiated by a multidisciplinary team, including midwives and consumers, in response to evidence confirming that supine going-to-sleep position in the third trimester of pregnancy was an independent risk factor for late stillbirth. The campaign plan included a follow-up survey evaluation.

Objectives: We aimed to evaluate the success of the campaign by surveying pregnant women and health professionals to assess their knowledge of the key campaign messages.

Methods: A two-part cross-sectional online survey was commenced in November 2019: 1) women with singleton pregnancy ≥28 weeks' and 2) health professionals who provide care for pregnant women in NZ. Descriptive statistics summarised data. Multivariate logistic regression identified factors associated with supine going-to-sleep position.

Results: In preliminary analysis, pregnant women were less likely to report supine going-to-sleep position (24 of 1935, 1.2%) compared with pregnant control women in previous NZ studies (3.9%, 2011 Auckland Stillbirth Study; 2.8%, 2017 NZ Multicentre Stillbirth Study). Few women (172 of 1571, 10.9%) reported feeling moderately-very worried about going-to-sleep position advice. Of 572 participating health professionals, including 413 midwives, 477 (86.3%) were aware of the association between supine going-to-sleep position and late stillbirth, and of these, 92.5% discussed going-to-sleep position with pregnant women.

Conclusion: The 'Sleep On Side When Baby's Inside' public health campaign messages appear to have been successfully disseminated and translated into modification of women's late pregnancy sleep practices in NZ, with the potential to improve birth outcomes for women and their babies.

D2

Reframing maternal health promotion – A holistic health model for midwifery

Eva Neely[1], George Parker[2], Susan Knox[3]

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[2]School of Midwifery, College of Health, Otago Polytechnic, Auckland

[3]Centre for Midwifery and Women's Health Research, AUT, Auckland

Health is multidimensional and incorporates physical, mental, social and spiritual domains. Pregnancy, birth, and the postpartum period are significant times of change for women, which may cause tensions between these different dimensions of health when engaging with health promotion. For midwives looking after women in this transformative time, there are equally tensions between the public health messaging expected of them, and women's actual health and wellbeing needs.

How to promote health is thus not a simple endeavour. Health promotion aims to enable people to "gain control over and improve their health". Implicit within this aim is empowerment, referring to an individual's ability to take control over their health. Research however shows that many 'health messages' expectant mothers receive are anything but empowering, and lack of attention to the structural and political forces inhibit control. The midwife is at the interface of such conflict and has to balance her responsibilities with the trust relationship she has with clients, alongside her professional values and ethics.

A practice model for maternal health promotion grounded in holistic health, justice and empowerment has the potential to aid women and midwives in their partnership. Anchored in health promotion principles and midwifery values we will present such a model, which will enable the discussion of a wide range of health topics in maternity care, including the social determinants and environmental factors affecting health. This model is designed to support a partnership model of care between midwives and women by promoting just, equitable and women-centered maternal health.

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Posters

Does continuity of midwifery care improve outcomes for the neonates of vulnerable women?

Alisha Aravena, Tiffany Henry[1]

[1]*Nelson Marlborough District Health Board, Nelson*

Background: Vulnerable women are susceptible to adverse neonatal outcomes.

Objective: To find what impact midwifery continuity of care (MCoC) has on neonatal outcomes compared to other care models.

Search Methods: Numerous databases were explored, and four out of twelve studies identified the impact of different models of care on neonatal outcomes.

Results: Midwifery continuity of care was associated with low rates of preterm birth and neonatal intensive care unit admissions. There was a slight decrease in low birth weight, small for gestational age, apgar scores and neonatal deaths, although results were mixed.

Conclusion: Midwifery continuity of care reduces adverse neonatal outcomes, therefore New Zealand midwives are uniquely positioned to provide care that reduces neonatal health disparities.

Key message: Continuity of midwifery care improves the outcomes of neonates born to vulnerable women.

Posters

Does work setting impact on midwifery burnout?

Nic Rankin[1], Janaya Coxon-Smith[1]

[1]Ara Institute of Canterbury, Christchurch

Background: Burnout is increasingly discussed in relation to midwives in New Zealand and there are increasing shortages of midwives around the country as listed in the Regional Skills Shortlist (New Zealand Immigration, 2019, p. 2-58). In New Zealand midwives can choose to be self-employed and manage a caseload of women in the community or be employed by a District Health Board (DHB) and work in a hospital setting.

Aim: The aim of this review is to identify if the setting midwives work within impacts on midwifery burnout.

Method: A comprehensive search of databases from the Ara Institute of Canterbury was conducted. Databases searched were PubMed, CINAHL, ScienceDirect and the Cochrane Library. Google Scholar was also used. Search terms used in various combinations were midwives and: case loading, lead maternity carer, community, LMC, continuity, core, hospital, burnout and stress.

Results: All of the studies used Copenhagen Burnout Inventory (CBI) and showed that midwives providing continuity of midwifery care reported lower levels of burnout.

Conclusion: Case loading midwifery has been shown to be associated with overall lower burnout scores than employed shift work. This is due to continuity of care being a protective factor for burnout. Regular time off for hospital-based midwives is protective in relation to burnout levels, while the on-call nature of case loading midwifery can increase burnout levels of midwives working in this setting.

Posters

Drinking or smoking while breastfeeding: Does it impact the child?

Louisa Gibson[1], **Melanie Porter**[1]

[1]*Macquarie University, North Ryde, Australia*

While the negative impacts of prenatal drinking and smoking are well documented, the potential impacts of drinking or smoking while breastfeeding on the child are largely unknown. Using data from the Growing Up in Australia study, the drinking and smoking behaviour of breastfeeding mothers was examined in relation to the cognitive, academic and health related quality of life outcomes of children at later ages. It was found that increased or riskier drinking during lactation was dose-dependently associated with decreases in abstract reasoning ability and academic scores at older ages in children, independent of prenatal exposure. No change in health related quality of life was observed, and smoking while breastfeeding was not related to any outcome variable. Drinking alcohol while breastfeeding my negatively impact a child's cognitive development and academic achievement. Abstaining from alcohol while breastfeeding may be the safest option for the child.

Posters

Maternal and fetal medicine; A new way forward for women and midwives

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Introduction to Counties DHB's newly formed Maternal and Fetal Medicine Midwifery team. This team has changed the way care is provided to women who require Specialist care for either themselves or their babies in utero.

By providing both clinic and case loading based care to these women and families by the same team of midwives, we can now provide both continuity and more steam lined care pathways for women accessing either one of often both services. Midwives work both within Specialist clinics offering midwifery support and in the community providing full ante and post natal care for a small caseload of women with Complex Care issues. They also provide support for LMC colleagues in a Shared Care capacity to allow them to feel more confident in continuing full care for women under their caseload.

This team is staffed by a team of 4 senior midwives, 2 at Specialist and 2 at Specialty level.

As a requirement of the positions each team member is required to complete a rigorous orientation programme focusing on both the specific roles and requirements of their position as well as gaining a knowledge of the external agencies and professionals that may be part of each woman's care package.

There is also an on-going Education Credentialing pathway ensuring both that practical skills and knowledge are kept up to date, including the requirement to complete the individually designed MFM Complex Care course, and that a clear and formal career progression pathway is in place for midwives within the team.

Posters

Maternal blood optimisation: A practice improvement strategy

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Introduction/Background: Although iron-deficiency and anaemia are common in pregnancy and postpartum, they are not managed consistently or well. This may be due to both a shortfall in clinical guidance, and the complexities of iron metabolism. This is problematic as anaemia is associated with increased morbidity, mortality and other adverse outcomes for women and babies.

Purpose: This clinical problem requires a multidisciplinary approach involving midwifery, obstetrics and anaesthetics. The Maternal Blood Optimisation (MBOP) practice improvement strategy aims to reduce rates of iron-deficiency and anaemia, improve perinatal outcomes associated with low iron status, and reduce anaemia associated interventions.

Project: A multidisciplinary team at Christchurch Women's Hospital have adapted Australian clinical pathways on the management of iron-deficiency anaemia (IDA) to their local setting. These evidence-based MBOP pathways target prevention and management of IDA for each trimester, intrapartum, and postnatal care. The pathways, guideline and educational resources are for use by midwives and doctors, from primary to secondary care, in both community and hospital settings. This practice improvement was implemented early in 2020, and will be audited.

Discussion: Despite the evidence gaps around the complexities of inflammation-mediated iron metabolism, there is still a strong evidence base for improved clinical pathways and consistency in the prevention and management of IDA in pregnancy and postpartum.

Key message: The MBOP pathways and resources provide useful clinical guidance on preventing and managing IDA in pregnancy and postpartum. This is important for midwives as they support women to achieve healthier pregnancies, recover from birth, breastfeed and parent their newborns.

Posters

One in three women

Janet Thackray[1]

[1]*Continence NZ, Auckland*

Introduction/Background: One in three women who have given birth will suffer from urinary incontinence, varying from small volumes when they cough to those that continuously flood their underwear.

Many women are not getting the help they need, often because they are too embarrassed to talk about it, told it is normal or are simply busy focusing on their new baby and put off their own health needs.

Purpose: Urinary Incontinence has a major impact on the lives of affected women. It causes increased rates of depression, and can lead to self-esteem and sexual dysfunction issues, an inability to exercise and even sometimes work, all of which can in turn lead on to an impact on family finances and contribute to relationship breakdowns.

In an ongoing survey of visitors to the Continence NZ website, running since May 2018, 87 percent say they have been concerned about their bowel or bladder health for more than a year, while 22 percent have had concerns for more than 10 years. For nearly half, visiting our site is the first time they have sought any help.

Project: We are creating a new mum-focused digital resource with clear information, tips and contacts for more help with returning to continence, which midwives will be able to direct post-natal women to via our website.

Discussion: Reclaiming their urinary continence is life-changing for women. There is plenty of help and support available, with various management and treatment options for this distressing and debilitating condition, available both in the public and private systems.

Key message: In her talk, Janet will cover the rates and impact of post-natal incontinence, the main causes and types and how they can be managed. She will also cover constipation prevention, bowel management, pelvic floor safe exercise – and how women can access further help.

New Zealand's wonderful midwives play such a crucial role for mums, and we would love their support to share our important message by helping us get our digital information packs to postnatal women in their care. We are planning to release this resource to tie in with your conference and we would to love to work with New Zealand's midwives to share and spread this knowledge and encourage the women of New Zealand to seek the help they deserve.

Posters

Small but pivotal: Hepatitis B and pregnancy

Diane Hanna[1]

[1]*Hepatitis Foundation of New Zealand*

Background: Hepatitis B is a major health issue. It can cause chronic infection and put people at high risk of death from cirrhosis and liver cancer. There are over 100,000 people in NZ living with chronic hepatitis B. About 50 percent of these are undiagnosed.

Purpose: Pregnant women with hepatitis B who have high viral loads have a 90 percent chance of passing it on to their unborn child. Women with high viral loads can be started on anti-viral medications to prevent transmission.

Project: In my daily practice I identified that midwives and midwifery students needed more education about the risk to unborn babies, so I put together a hepatitis B and pregnancy presentation, which the Midwifery Council of NZ approved.

Discussion: When women are referred in time it can decrease the chances of passing the virus to their baby and improve the health outcomes for both mother and child.

Key message: Midwives can help women with hepatitis B and their babies achieve much better health outcomes. With consent, they can enrol women into the Hepatitis Foundation of NZ's long-term hepatitis B monitoring programme; this helps with early detection of serious liver disease.

Posters

Supporting midwives to support women – Advocating for professional supervision

Amanda Rouse[1]

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Background: The midwifery profession in New Zealand is under pressure. The reasons for this are multi-faceted, with employed and community midwives working less hours along with midwives leaving the profession. However, more midwives than ever hold practising certificates in New Zealand.

Therefore, aside from improved pay and conditions, what other strategies are available to allow midwives to work more hours and improve retention?

Objective: The concept of professional supervision is explored within the context of improving midwives' wellbeing and utilising strategies that allow midwives to grow stronger together.

Method: A literature review was conducted utilising the PICOT Framework, to explore how professional supervision is utilised in other health professionals and whether a programme of supervision could improve midwifery retention and wellbeing.

The review demonstrated that midwives experience distress for a variety of reasons, in various settings and practice across the world. Themes included:

- The passion for midwifery leads to over commitment and burnout
- Understaffed and under-resourced
- The clash of two philosophies
- Lack of support following adverse events
- Midwives share the woman's trauma

Results: Professional supervision was found to be common in similar professions (mental health nurses, social workers and health visitors) and in midwifery in the United Kingdom, with supervision demonstrating improved wellbeing amongst those professions.

Conclusion: Midwives are exposed to traumatic events that can lead to Post Traumatic Distress Disorder, anxiety, stress and burnout. Midwives may also become the second victim following adverse events. Through Restorative Clinical Supervision midwives can develop skills to help them manage complex situations and events.

Key message: A programme of supervision is one of many suggestions to improve midwifery wellbeing and improve the care provided to women and whānau in New Zealand. Midwives need to be supported to grow stronger together through a locally designed programme of midwifery that incorporates the uniqueness of midwifery in Aotearoa New Zealand.

Posters

Teaching Intact Cord Resuscitation

Tina Hewitt[1]

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Background: The evidence around the timing of cord clamping has consistently demonstrated improved infant outcomes resulting from increased placental transfusion. While deferred cord clamping is now common for healthy term neonates, it cannot be safely implemented for babies that fail to breathe at birth without a knowledge of intact cord resuscitation (ICR). Training in newborn resuscitation should not start with the baby on the resuscitaire but before, when the baby is first born and is attached to its mother by the umbilical cord. So much critical decision-making takes place in the first minute after the birth and this impacts on whether or not the baby receives vital placental transfusion.

Objective: The objective of this innovative educational practice is to present a way in which ICR can be taught as part of newborn life support training to boost the confidence and understanding of birth practitioners.

Methods: Teaching ICR is a relatively new practice for most educators and I will demonstrate how simulation training may be adapted to encourage health professionals to extend the time for placental transfusion, without compromising the newborn by delaying resuscitation.

Results: The implications are for a wider transfer of the message of ICR and the resulting improvement in neonatal outcomes.

Conclusions: Demonstrating ICR and providing an opportunity to practice this skill may improve a practitioner's ability to make rapid and appropriate decisions at birth about when and whether to transfer a baby to a resuscitation table.

Key message: Renaming newborn resuscitation: supporting newborn transition

Posters

What are women's views and attitudes towards vaccination in pregnancy?

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Vaccination for Pertussis and Influenza is recommended by the Ministry of Health for all women in pregnancy in Aotearoa. This research aims to look at women's knowledge and views on these vaccinations and how it impacts on their decisions. Three research articles were reviewed and themes were compared and contrasted. Women's decisions were most influenced by healthcare professional's advice and their own understanding of the safety and risks of the vaccinations.

Women want more information about these vaccinations from their healthcare provider. Education for midwives on these vaccinations could support this as well as the partnership and continuity model in Aotearoa midwifery creating trust between the women and midwives. Women and their whanau should be supported to make an informed decision about vaccination in pregnancy and midwives are well placed to provide this knowledge and choice.

Posters

Why chiropractic is a wonderful tool during pregnancy: A closer look to the Webster Technique

Virginie Desjardins[1]

[1]*The Connection, Auckland*

Background: Throughout the end of the pregnancy, the baby's position is often a concern for the mother who seek a natural and comfortable birth. Often, the mother has no other option than to go through the external cephalic version, which can be painful and very stressful for the mom and baby.

Chiropractic uses a gentle technique call Webster that focuses on releasing the extrauterine constraints so that baby has all the space he needs to turn by himself like his instinct tells him to do. The Webster Technique will also ensure that the mother's body is in its optimal state to give birth.

Focus of the discussion: In most cases, baby will adopt a vertex position between the 28th and 35th week. If there is any extra uterine tensions or stress, it will affect the space that the baby needs to turn.

Many external structures can be implicated in creating tension in utero whether it is an osseous biomechanical dysfunction, tensions in ligaments or tightness in muscles. The Webster Technique provides an accurate analysis of the sacroiliac joints and the related soft tissues around and enable the chiropractor to release tensions with chiropractic adjustment. Therefore, the body can allow more space for the baby to turn and ensure an easier passage at birth.