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FORUM ABSTRACTS

Joan Donley Midwifery Research Forum 2026 abstracts

10-MINUTE ORAL PRESENTATIONS

Sustaining midwifery group practice: Insights from established groups across Aotearoa New Zealand

Cara Baddington[A,B], Susan Crowther[C], Lorna Davies[D], Celia Grigg[E]

[A] Presenting author: cara.baddington@op.ac.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago
[C] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[D] Independent Midwifery Researcher and Consultant
[E] Independent Midwifery Researcher

Background: Midwifery Group Practices are central to sustaining continuity of care in Aotearoa New Zealand. Many community-based midwives practise in group settings where responsibility of practice organisation is shared. However, there is limited, practice-ready guidance on how groups organise for sustainability and equity in real world contexts.

Aim: To identify cross-domain, practice-ready strategies that sustain midwifery group practices and can be adapted to diverse contexts, supporting equitable delivery of care.

Method: We conducted a multistage qualitative descriptive study with an appreciative inquiry lens. Data sources comprised: a national anonymous survey, a face to face workshop, and multiple focus groups with established and longstanding group practices across regions throughout Aotearoa New Zealand. We used template analysis to progress from domain identification to intra /cross group synthesis and actionable outputs. Early discussions with Tangata Whenua midwives informed the initial planning of the study and helped ensure the research was appropriately situated within the maternity context of Aotearoa New Zealand.

Findings: Across the data a consistent pattern emerged: sustainable midwifery group practices function as intentional communities, balancing relational depth (shared philosophy, whanaungatanga, mutual support) with operational clarity (written communication protocols, predictable rosters and debriefs, structured recruitment and onboarding, transparent finances). One without the other is insufficient. Key domains included philosophy and culture ("the glue") expressed in everyday practice; relationships and communication; work-life balance supported through rostering and after hours phone management; money matters; and governance with light touch roles and responsibilities. Recruitment and onboarding also emerged as an important theme, shaping how new members integrate into group practice.

Conclusion: Sustainability in midwifery group practices is both cultural and structural. Codifying small, low cost routines amplifies relational ethos, protects midwives' wellbeing and helps to sustain continuity of care for women and whānau.

Maternity triage: A nice-to-have or a necessity? A clinical audit of acute maternity presentations at Waikato Hospital

Sam Coffey[A,B]

[A] Presenting author: samantha.coffey@waikatodhb.health.nz
[B] University of Waikato | Te Whare Wānanga o Waikato

Background: Waikato Hospital, the tertiary centre for Te Manawa Taki region, provides a range of services, including a 24/7 Women's Assessment Unit (WAU) for acute maternity care. Unlike the hospital's emergency department, WAU does not have a well-established triage system. It is unclear whether women presenting to WAU receive an initial assessment in a timely manner and whether care is prioritised according to clinical urgency. Aotearoa New Zealand experiences significant maternal health inequities, and it is unknown how these women are represented among WAU presentations.

Objectives: The primary objective of this clinical audit was to determine whether women presenting acutely to WAU were assessed in a timely manner and prioritised according to clinical urgency, using the modified Obstetric Triage Acuity Scales (OTAS). A secondary objective was to explore the sociodemographic characteristics of women, including ethnicity and deprivation decile, to identify potential inequities in care.

Method: A retrospective audit of clinical documentation was undertaken, comparing assessment times and practices against modified OTAS standards. Ethnicity and deprivation data were collected to better understand the population accessing WAU.

Findings/Results: The audit revealed delayed assessment times and inconsistent triage processes. Māori women represented the largest ethnic group (39.6%) and were significantly over-represented in the highest deprivation deciles. There was no statistically significant relationship between triage score and time to be seen ($p = 0.25$, $R^2 = 0.0989$) with wide variation across triage levels. Overall, findings indicate inequities in access, poor alignment between clinical urgency and timeliness of care, and the need for a standardised triage framework within WAU.

Conclusion: This audit highlights the need for a structured maternity triage system for acute presentations. Implementation of a tested triage framework could improve timely assessment, support clinical decision-making, and enhance equitable outcomes for women in WAU and potentially across maternity services nationally.

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Joining midwifery group practice: Recruitment, onboarding and belonging in sustainable groups

Lorna Davies[B,] Cara Baddington[A,C,] Susan Crowther[D,] Celia Grigg[E]

[A] Presenting author: cara.baddington@op.ac.nz
[B] Independent Midwifery Researcher and Consultant
[C] Otago Polytechnic | Te Kura Matatini ki Otago
[D] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[E] Independent Midwifery Researcher

Background: Midwifery Group Practices (MGPs) are instrumental in sustaining continuity-of-care within Aotearoa New Zealand's maternity system. While studies have examined outcomes and experiences associated with caseloading midwifery, less attention has focused on recruitment and integration of new members into existing practices. Joining an MGP involves more than signing a contract; it requires relational, professional and cultural integration within a shared community of practice.

Aim: To examine recruitment and onboarding processes within MGPs, drawing on findings from a wider study exploring the sustainability of MGPs in Aotearoa New Zealand.

Method: The presentation draws on findings from a multistage qualitative descriptive study framed by appreciative inquiry. Data sources comprised a national anonymous survey, a face-to-face workshop, and focus groups with longstanding MGPs across New Zealand. Template analysis enabled identification of patterns across practices and development of practice informed insights. Early discussions with tangata whenua midwives informed study planning and ensured the research was appropriately situated within the maternity context of Aotearoa New Zealand.

Findings: Recruitment and onboarding were identified as critical to MGP sustainability, highlighting how integration of new members contributes to long term cohesion and resilience. Well-functioning groups view recruitment as an opportunity to evaluate philosophical alignment, relational compatibility and shared expectations regarding caseload responsibilities. Effective onboarding processes included trial working periods, structured mentorship, gradual transition into caseloads, and explicit communication and financial agreements. These supported safe integration of new members into both the interpersonal culture and operational systems of the group. Participants emphasised that such structures were especially important for new graduate midwives transitioning into autonomous continuity-of-care practice.

Conclusion: Successful integration into an MGP requires both relational belonging and operational clarity. Strengthening recruitment and onboarding processes can enhance midwives' wellbeing, support group cohesion, and contribute to the long term sustainability of continuity of care models in Aotearoa New Zealand.

How can I help? An acceptability novel maternity care provision in remote rural Murihiku

Pauline Dawson[A,B,] Jean Hay Smith[B,] Tim Stokes[B]

[A] Presenting author: pauline.dawson@otago.ac.nz
[B] University of Otago | Ōtakou Whakaihu Waka

Background: Providing midwifery care in remote rural communities can be challenging for LMC midwives and place additional demands on whānau who need to travel for their care.

Aim: Is a "drop-in" remote rural maternity clinic to improve access to care in hard to service areas, an acceptable option to these communities and maternity caregivers?

Methods: A monthly pilot "drop-in" clinic was implemented in Tokanui, Southland. Field notes were taken during this phase. After embedding, an anonymous online survey was circulated inviting people using the clinic, their families, the wider community, local health care providers, and other stakeholders in maternity care provision to participate. At the end of the survey there was an invitation to participate in a semi-structured interview.

Descriptive statistics were collated from the survey. Thematic analysis was completed for free text survey responses and interview transcripts. Analysis focused on the acceptability and feasibility of the new model of rural maternity care and was informed by the Consolidated Framework for Implementation Research (CFIR) and Levesque access framework.

Findings: Rural families expressed they would prefer to have their own LMC within their communities. When this isn't available, the community noted that the clinic model could mean some care could be provided closer to home so family could be involved and remove some travel/time costs. While identified as potentially useful, maternity providers had concerns that the clinic model might interrupt the partnership developed under the continuity model.

Conclusion: Communities could see potential in the clinic service, but better socialisation was needed for both them and maternity carers. Communicating how a novel mode of care outside the LMC model is important for successful implementation but can be challenging in remote regions.

Use and safety of ondansetron during pregnancy: Findings from the New Zealand Pregnancy Cohort 2005-2020

Sarah Donald[A,B,] Katrina Sharples[B,] Dave Barson[B,] Karyn Maclennen[B,] Leanne Te Karu[C,] Diana Phone[D,] Hedwig van Asten[E,] Michael Stitely[E,] Leanne Te Karu[B]

[A] Presenting author: sarah.donald@otago.ac.nz
[B] University of Otago | Ōtakou Whakaihu Waka
[C] The University of Auckland | Waipapa Taumata Rau
[D] Te Whatu Ora | Health New Zealand – Waitematā
[E] Te Whatu Ora | Health New Zealand – Southern

Background: Antiemetics are appropriate for managing nausea and vomiting in pregnancy (NVP) if non-pharmacological measures are unsuccessful. Ondansetron is effective for NVP, but recent evidence suggests a small increased risk of congenital malformations, particularly cleft lip/palate.

Aims: The aims were to i) describe patterns of antiemetic use during pregnancy in Aotearoa New Zealand, and ii) explore potential associations between first trimester ondansetron exposure and congenital malformations and other pregnancy outcomes.

Methods: A cohort study was undertaken using the New Zealand Pregnancy Cohort. Community-based antiemetic dispensings were linked with cohort members to determine exposure. Antiemetic use was described by calendar time and sequence of dispensing. For those dispensed ondansetron, the first dispensing was explored in relation to hospital admission for NVP and the prescriber type. Potential associations between first trimester ondansetron exposure and congenital malformations, stillbirth, preterm delivery, and small for gestational age (SGA) were analysed.

Findings: From 2005-2020, the use of any antiemetic in Trimester 1 increased from 4.1% to 21.1% of pregnancies, with a substantial increase in ondansetron use from 0.1% to 9.8%. Among those dispensed an antiemetic, ondansetron as first-line treatment also increased over time. Initially, junior doctors and obstetricians provided the majority of first prescriptions, whereas more recently they were predominantly from general practitioners, junior doctors and midwives. Ondansetron was not associated with an increased risk of major congenital malformations overall, but small increased risks of cardiac malformations or cleft lip/palate could not be ruled out. Stillbirth, preterm delivery, and SGA were not increased.

Conclusion: Ondansetron use during pregnancy increased substantially over time. Most adverse outcomes were not increased after ondansetron use, but a small increased risk of some malformations could not be ruled out. Some caution with prescribing is still warranted.

Resistance is fertile: The Global Critical Midwifery Summit

Annabel Fakhri (Farry)[A,B], **George Parker**[B], **Heather Came**[B]

[A] Presenting author: annabel.farry@op.ac.nz
[B] Te Herenga Waka – Victoria University of Wellington

Background: Critical Midwifery Studies calls us to recognise our complicity in intersecting economic, racialised, gendered and class-based forces shaping midwifery education and practice. The Aotearoa Midwifery Project developed Standards of Competence to give effect to Te Tiriti o Waitangi and Cultural Safety in education. However, inclusive and Indigenous language remain contested and Te Tiriti o Waitangi itself is being legislatively challenged. Furthermore, racial inequities persist in perinatal mortality and morbidity both locally and globally. Reproductive and perinatal infrastructures are either actively destroyed and sanctioned or over-medicalised and legislated against.

Aim: This doctoral research asks, "Can Critical Midwifery Studies strengthen an epistemology of resistance?" This presentation reports one component: what the Global Critical Midwifery Summit (GCMS) made speakable and how gathering together felt.

Method: The wider doctoral study includes 24 key-informant interviews. This presentation reports only the four-hour GCMS, where ten invited key informants presented in response to CMS. Informed by critical realism and standpoint theory, voices from Māori, Indigenous, gender-diverse, neurodiverse and Global Majority communities were prioritised. The Summit recording was analysed using reflexive thematic analysis.

Findings: Analysis generated three themes: Making truth speakable; Feeling disposable; and Finding our whānau. Gathering enabled embodied, culturally held and politically dangerous truths to be voiced and recognised. Feeling disposable captured the pain of being unheard, dehumanised or excluded through intersecting colonial, racialised, classed, ableist, gendered and trans-exclusionary forces. Finding our whānau captured the relief and strength of being seen, heard, understood and embraced in our complexity within a shared kaupapa.

Conclusion: Midwifery learning and teaching is being challenged to make a paradigmatic turn, requiring spaces that support critical truth-telling, Indigenous authority and collective resistance while sustaining intersectional solidarity amid intensifying local and global tensions. Consciously gathering across difference is central to this work.

Exploring factors that support LMCs to provide birth care at a primary birthing unit, and building research capacity

Anna Fielder[A,B], Ayla Fraser[C], Waimarie Onekawa[B,D]

[A] Presenting author: anna.fielder@aut.ac.nz
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[C] Pasifika Midwives Tāmaki Makaurau
[D] Rua Pōkai Ngā Maia i te Rauroha

Background: Nga Hau Māngere Birthing Centre opened in 2019 in Māngere – an area of South Auckland with a culturally rich community, including the largest population of Pacific Peoples in Aotearoa. Approximately 75% of people birthing at Nga Hau Māngere identify as Māori and/or Pasifika. The birth centre has recently undergone changes in organisational arrangements, alongside an increase in the number of whānau birthing there. Given this period of transition, summer 2025/26 presented a timely opportunity for a project to both explore facilitators of primary birthing in this context and enhance local midwifery research skills.

Aim: The paper presents the process and findings of a study in which a third-year Pacific student midwife worked as a researcher. The research aimed to identify, from the perspective of LMC midwives, what supports them to provide birth care at this primary unit.

Methods: The research employed a short, anonymous online survey aimed at LMC midwives in the Tāmaki Makaurau region. Data were analysed using descriptive statistics and thematic analysis.

Findings: 35 midwives completed the survey. Amongst respondents there were high levels of agreement that the service at Ngā Hau Māngere Birthing Centre aligns well with their midwifery philosophy. Over 45% were interested in attending an education event to enhance their skills and confidence in primary birthing. Midwives identified features of the environment and staffing as important in supporting them to provide intrapartum care at the unit. The research process resulted in a student midwife expanding her knowledge of research and primary birthing, in a collaborative environment.

Conclusion: The project contributed to building research capacity within the growing Pacific midwifery community, and highlighted ways of enhancing midwifery confidence in providing birth care in a primary unit setting.

Upholding mana through vaginal examination experiences

Susie Fothersgill[A,B], Karen Wakellin[B], Suzanne Miller[B]

[A] Presenting author: susie@journeyman.co.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago

Background: In Aotearoa New Zealand, vaginal examinations are deemed an essential assessment during labour and birth that assesses both the start and progression of labour, despite evidence of the efficacy being inconclusive.

Aims: To identify birthing people's knowledge and acceptability of why vaginal examinations may be offered during labour and birth; and to identify factors that contribute positively or negatively to a birthing person's experience of vaginal examinations.

Methods: A qualitative descriptive study using a single semi-structured kanohi-ki-te-kanohi (face to face) interview with primiparous birthing people who had experienced vaginal examinations during spontaneous onset of labour between 2022 and 2025. The data was analysed using reflexive thematic analysis.

Findings: 16 interviews were conducted with primiparous birthing people across the motu. Preliminary findings identified one theme and three sub-themes. Safeguarding birth was the overarching theme and highlighted participants' core values that safeguarded birth. The three sub-themes included: Sub-theme one, knowledge as a tool, which emphasised how knowledge around vaginal examinations can enhance birthing people's ability to ask the right questions around vaginal examination assessments; Sub-theme two, autonomy and informed consent illustrated birthing peoples understanding of body autonomy and their experiences of their choices being supported; and Sub-theme three, feeling safe in the birth space incorporated those aspects within the environment that participants felt allowed them to feel both physically safe and emotionally secure.

Conclusion: Those participants who explored additional resources about vaginal examination assessment were able to have more robust discussions with their care providers about the scenarios they would or would not accept a vaginal examination. Autonomy and informed consent were generally respected; however, not all birth settings facilitated vaginal examination choice for birthing people. Feeling safe in the birth space had a positive contribution to birthing people's experience of vaginal examinations.

The vessel of service: Collective wellbeing and sustainability for Pacific LMC midwives

Talei Jackson[A,B], Eleanor Holroyd[B], Sione Vaka[C], Janine Clemons[B]

[A] Presenting author: taleivejackson@gmail.com
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[C] University of Waikato | Te Whare Wānanga o Waikato

Background: Global midwifery sustainability discourse is largely viewed through Western individualism, focusing on burnout and attrition as individual experiences. For the Pacific workforce in Aotearoa – representing only 4% of the profession – this overlooks the collective responsibility and cultural essence inherent in their practice. Understanding sustainability is vital, as it directly impacts workforce longevity and Pacific birthing communities' health outcomes.

Aim: This inquiry explores the longitudinal sustainability of Pacific LMC midwives through a collective wellbeing lens. Central to this study is the question: "What sustains Pacific midwives in LMC practice in Aotearoa?" Shifting from deficit-framed narratives, the study seeks to understand the lived experiences of Pacific midwives, and their families, to identify foundations for a culturally congruent, flourishing workforce.

Methods: Grounded in the Tanoa ni Veiqaravi (vessel of service) framework, this doctoral research utilises the dialogic method of Veivosaki-Yaga (worthwhile discussion). The study prioritises relational integrity, gathering stories from Pacific midwives and their families. Reflexive thematic analysis was employed to ensure an insider perspective that balances clinical knowledge with Indigenous relational ethics, providing a rigorous and transparent approach to collective narratives.

Findings: Pacific midwifery sustainability is inextricably linked to the wellbeing of the family. Learning from collective narratives, this research identifies that the weight of LMC care is navigated through a complex web of relational support and shared sacrifice. Findings suggest true longevity emerges when systems recognise the midwife as a conduit of collective service rather than an isolated unit of labour.

Conclusion: Sustainable practice models must be grounded in culturally responsive inquiry to uncover Pacific-led solutions. By weaving lived interdependence with Indigenous logic, this work establishes a self-determined pathway for a resilient workforce. Ultimately, sustainability is found in binding professional duty with communal strength. When the system supports the collective, Pacific wellbeing and longevity are enabled.

The abortion midwife: Negotiating midwifery identity post abortion law reform

Fleur Kelsey[A,B], Chloe Parton[B], Octavia Calder-Dawe[B]

[A] Presenting author: fleur.kelsey@op.ac.nz
[B] Te Herenga Waka | Victoria University of Wellington

Background: The 2020 decriminalisation of abortion in Aotearoa New Zealand marked a significant shift in reproductive health policy, enabling kahu pōkai to provide early medical abortion (EMA) within their scope of practice. Despite this legal change, few kahu pōkai have taken up the role of abortion providers and little is known about how kahu pōkai interpret this legislative shift or how it intersects with their professional identities. While global literature highlights a persistent emotional and affective tension surrounding abortion work among midwives, this has not been explored in the context of EMA after abortion law reform in Aotearoa.

Aim: This paper explores findings from my PhD with the following overarching research questions: How has midwifery-led abortion provision been constructed by midwifery professional and regulatory bodies? How are midwives making sense of midwifery-led abortion and negotiating the possible implications for midwifery identity and practice?

Method: 21 semi structured interviews were undertaken July 2025-March 2026 with kahu pōkai in Aotearoa who are currently providing or considering providing EMA. An affective-discursive practice approach was used for analysis.

Descriptive statistics were collated from the survey. Thematic analysis was completed for free text survey responses and interview transcripts. Analysis focused on the acceptability and feasibility of the new model of rural maternity care and was informed by the Consolidated Framework for Implementation Research (CFIR) and Levesque access framework.

Findings: Kahu pōkai are making decisions about the provision of EMA in an affective atmosphere which requires ongoing negotiation and construction of midwifery identity. Kahu pōkai are both constrained by, and actively resisting, the discourse of abortion as a contested, stigmatised and stigmatising part of reproductive health care.

Conclusion: Integrating abortion provision into midwifery is not solely a logistical or clinical task; it is a deeply affective, political, and identity-shaping process. Recognising and addressing these emotional and systemic dimensions is essential to supporting kahu pōkai to provide EMA, improving access to safe and equitable abortion care, and advancing reproductive justice for all people who can become pregnant in Aotearoa.

Reclaiming power and peace. Protective factors for positive birth: a qualitative exploration

Anna Krakosky[A,B], Suzanne Miller[B], Annabel Farry[B]

[A] Presenting author: akrakosky@yahoo.co.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago

Background: Birth is often evaluated through clinical outcome measures with less priority given to the lived experience and feelings of the birthing person. Yet, the psychological consequences of traumatic birth are well documented, and growing evidence suggests that positive perceptions of birth have a protective effect on postnatal mental health.

Aim: This study asks; what factors influence people's perception of the experience of birth in a positive way?

Methods: Using Qualitative Descriptive methodology, face-to-face semi-structured interviews were conducted with participants who self-identified as having had a positive birth experience. Reflexive thematic analysis was used to explore and interpret the data.

Findings: Participants gave birth in a range of settings and were both first-time parents and those expanding their families. As well as the environment and relationships, the cultivated internal environment of the birthing person was emphasised as particularly influential to positive birth experience, highlighting the power of mental preparation and mindset.

Conclusion: The findings support an argument that consciousness plays a central role in shaping birth experience and resonate with the established theory of altered states known as Set and Setting. When viewed through this lens, elements such as preparation, positive mindset and the presence of supportive, trusting relationships come together as mutually reinforcing influences, offering a compelling explanation for how a positive birth experience may be cultivated.

Key message: There is much we can do to bolster belief in self and belief in birth, both of which positively influence how the experience is perceived. Considering birth using a Set and Setting framework offers an additional tool for both consumers and providers to reflect on, and use to challenge current practice realities, fostering environments that centre agency, trust and a deep sense of safety.

He Kahu Pōkai ahau

Beatrice-Ann Leatham[A,B,C]

[A] Presenting author: bealeatham@hotmail.com
[B] Ngā Māia Trust
[C] New Zealand College of Midwives | Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa

This research explored the intricate nature of Indigenous midwifery within Aotearoa. The context has largely been constructed through an ethnocentric worldview and there is very little written that explores the understandings of being a Kahu Pōkai. This presented a sense of urgency to document distinctively Māori maternity knowledge. Evidence shows many Indigenous whānau are unable to access care that enhances their childbirth experience, endure inequitable maternity outcomes and culturally unsafe experiences. This research aimed to reveal the uniqueness of Māori midwifery practice.

'He Matatauihi i ngā Ururei Whēako hei Kahu Pōkai' resonates the focus of this study. 'Matatauihi' refers to the sacred role of calling spiritual and physical energies to kaupapa by the female voice. 'Ngā Ururei' conveys the ancient practices that are guided by the knowledge of deities. 'Wheako' is the experiences gained by the human being and 'Kahu Pōkai' refers to the absolute commitment, and unique passion that is activated for mama and their pepi. This title locates the nature of Māori midwifery and childbirth. It exerts knowledge systems of both the tangible and intangible, acknowledges the responsibility of nurturing whakapapa and offers an insight to the privileged potential of this position.

Nine Māori midwives told their stories. Their insights build upon a limited source of literature on Māori midwifery. Kaupapa Māori and Mana Wahine were crucial theoretical frameworks that allowed distinct Indigenous systems of knowledge to be integrated into the research. Hence, a traditional Māori pedagogy of learning was implemented. Te Whare-kōrero ā Kahu Pōkai provided the philosophical underpinning to ground the research in mātauranga Māori and specific to Kahu Pōkai. Preferencing knowledge in this way revealed Māori midwives practise in a transformative manner. They innately resist the patriarchal systems in which Māori maternities currently dwell to assert tino rangatiratanga of themselves and birthing whānau.

What are the experiences for early career continuity of care (LMC) midwives in Aotearoa New Zealand in screening or assessing perinatal mental health? Findings from a doctoral study

Michele Lomax[A,B], Susan Crowther[B], Julie Blamires[B]

[A] Presenting author: michelelomax2013@gmail.com
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: Perinatal mental health is a critical component of continuity of midwifery care and a key equity issue in Aotearoa New Zealand. Internationally, up to 15% of pregnant people experience perinatal mental health distress, with many cases remaining unidentified. In Aotearoa New Zealand, suicide is the leading cause of maternal death, with Māori wāhine disproportionately affected. This inequity reflects the ongoing impacts of colonisation and systemic barriers within health services. Continuity of care midwives are well positioned to identify distress early through sustained relationships grounded in partnership.

Aim: To explore the experiences of early career continuity of care midwives in screening for perinatal mental health in Aotearoa New Zealand, with attention to equity and Te Tiriti obligations.

Methods: This study used Sally Thorne's Interpretive Description qualitative methodology to generate practice relevant knowledge. Nine midwives from across the motu participated in semi structured interviews conducted face to face or virtually. Interviews were transcribed verbatim and analysed using reflective thematic analysis.

Findings: Three main themes were identified: "Walking the line between conversation and questioning: Midwives' use of formal and informal screening approaches", where midwives learned the method of screening that worked best for them; "Knowing, noticing, and gaining confidence: Midwives normalising conversations about perinatal mental health", where midwives used innate knowledge to notice changes in mental health; and "Holding the burden of care within boundaries: Navigating referral decisions, waiting, and ongoing responsibility", where midwives held the responsibility while waiting on referrals to be answered.

Conclusion: Early career midwives reported reduced confidence in perinatal mental health screening due to unclear referral pathways and limited access to timely, culturally responsive services. Delayed or declined referrals increased midwives' responsibility for whānau safety, contributing to emotional labour and stress. Strengthening referral pathways, resourcing continuity of care, and upholding Te Tiriti-informed, equity-focused mental health services are essential to support midwives and improve outcomes for wāhine and whānau.

Our First Mothers speak

Jacqueline Martin[A,B]

[A] Presenting author: Jacqueline.martin@ara.ac.nz
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau

Background: Despite a body of Māori scholarship emphasising the intimate relationship between Māori cosmogony and birthing, midwifery education in Aotearoa remains grounded in Eurocentric ideologies. Consequently, Māori midwifery students will graduate as Pākehā-trained midwives who happen to be Māori. This rangahau centres the Māori midwives' silenced voices, revealing cultural disconnection and pervasive imposter syndrome that adversely affect cultural identity, confidence and midwifery practice.

Aim: This rangahau employed a decolonising approach to explore how the midwifery profession of New Zealand contributes towards nurturing and nourishing the mana and mauri of Māori midwifery graduates; and supports the reclamation and revitalisation of Tāpuhitanga as Māori midwifery praxis.

Method: A qualitative research design guided by Kaupapa Māori, Mana Wahine and Indigenous Storywork through Our First Mothers: An Indigenous midwifery philosophy of Aotearoa. Twenty-six participants, including kaumātua, midwifery graduates and Indigenous birth workers, were recruited through purposive sampling. Pūrākau informed all research phases. Thematic analysis was supported by Ka Puta Ki Waho and identified four key themes: Kurawaka (pathways into midwifery), Ūwha (identity in midwifery), Manawa (impactful clinical practice) and Whare Tangata (belonging in midwifery).

Findings: The key drivers for many participants entering midwifery as a career was to provide for their whānau and a commitment to women and childbirth. Midwifery training revealed divergent experiences; Māori graduates described marginalisation and professional isolation, while Pākehā graduates emphasised clinical expertise. Following adverse outcomes, participants reported feeling silenced and dehumanised. For Māori midwives, this fuelled further marginalisation and increased professional vulnerability. .

Conclusion: Beneath the veneer of midwifery partnership is the disruption to Māori ways of knowing and being in midwifery. Reclaiming Tāpuhitanga as Māori midwifery praxis may enrich the midwifery education for Māori. This highlights the unique contribution Tāpuhitanga can make in the midwifery profession of Aotearoa New Zealand.

Reimagining research: Verbatim theatre and creative methodology in the study of teenage pregnancy

Rebekah Matsas[A,B], Annabel Farry[B], Suzanne Miller[B]

[A] Presenting author: rebekahmatsas@outlook.com
[B] Otago Polytechnic | Te Kura Matatini ki Otago

Creative methodologies are increasingly recognised as rigorous and transformative tools within qualitative research, yet their role in academic inquiry is still evolving. This presentation examines verbatim theatre as a methodological framework within a Master's project exploring the lived experiences of teenagers who become pregnant. By positioning verbatim theatre as both a research method and mode of knowledge production, this work argues for broader acceptance of creative approaches within academic scholarship.

This project draws on contemporary work in creative research, community of practice experience and applied theatre to bring to life the voices of people whose experiences are often shaped by social stigma and institutional narratives. This presentation outlines the study's methodological design, including ethical considerations, interview approaches and the creative processes involved in shaping stories into theatrical form.

In addition to discussing verbatim practice, the presentation reflects on the researcher's own creative process of writing a play based on personal experiences of teenage pregnancy. This autoethnographic layer highlights how self-reflection, creative vulnerability and personal narrative can inform and strengthen the research process. Engaging with one's own story becomes both a methodological tool and a way of examining the emotional, ethical and artistic labour inherent in creative research.

Together the methodological strands demonstrate how creative practice can function as a valid, nuanced and impactful form of academic inquiry. This project advocates for the increased integration of creative methodologies, particularly verbatim theatre, as valuable frameworks for researching sensitive social phenomena and expanding the possibilities of knowledge-making within academic research. Within this context, verbatim theatre deepens impact by presenting lived experiences with immediacy and emotional resonance, allowing audiences to engage more deeply and connect with the complex realities represented.

LGBTQIA+ equity initiatives in pre-registration midwifery education: An intercontinental study

Suzanne Miller[A,B], Sally Pezaro[C], Elizabeth Newnham[D], Vicki van Wagner[E], George Parker[F], Fleur Kelsey[B]

[A] Presenting author: suzanne.miller@op.ac.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago
[C] Coventry University, United Kingdom
[D] Flinders University, Australia
[E] Toronto Metropolitan University, Canada
[F] Te Herenga Waka | Victoria University of Wellington, Aotearoa

Background: In many countries, more gender- and sexuality-diverse people are forming families through birth of their own children, partly influenced by changes in the law, technology and increasing social acceptance. This necessitates a midwifery workforce that is well prepared, to ensure provision of culturally and clinically safe care for LGBTQIA+ parents. Evidence confirms that parents within the rainbow community generally, but particularly within the trans and non-binary community, have poorer outcomes and experience discrimination within perinatal care systems that are normatively set up for cisgender heterosexual couples. Further evidence suggests that midwives desire support to improve their practice competence in this area. To date little is known about how pre-registration midwifery programmes embed curriculum content that supports student midwives to build their competency and cultural humility when providing care to LGBTQIA+ families, nor what education programmes do to support LGBTQIA+ midwifery students.

Aim: The study aimed to explore the current situation in relation to teaching midwifery care for LGBTQIA+ people within the pre-registration programmes of midwifery schools across Aotearoa, Australia, Canada and the UK.

Method: An anonymous online survey, hosted on the Qualtrics platform, was conducted during February and March 2026. Numerical data were analysed using descriptive statistics and qualitative comments were summarised using content analysis.

Results: 61 midwifery educators (Australia n = 18, Aotearoa n = 17, United Kingdom n = 14, Canada n = 12) completed the survey. Most Schools of Midwifery have dedicated learning content related to providing midwifery care for LGBTQIA+ families, but there are wide variations in curriculum content and delivery. 88%

of respondents felt at least 'moderately' confident about teaching this content and 98% agreed that teaching this content was 'very' or 'extremely' important.

Conclusion: Clear strategies were offered to support midwifery educators with teaching and learning in this content area, and the need to better support LGBTQIA+ midwifery students was highlighted.

"Between hope and despair": LGBTQIA+ student experiences in pre-registration midwifery education in Aotearoa

George Parker[A,B], Fleur Kelsey[C], Chloe Parton[B], Clive Aspin[B], Lee Bravestone[B], Nicola Paton[D]

[A] Presenting author: george.parker@vuw.ac.nz
[B] Te Herenga Waka | Victoria University of Wellington, Aotearoa
[C] Otago Polytechnic | Te Kura Matatini ki Otago
[D] The University of Auckland | Waipapa Taumata Rau

Background: The experiences and perspectives of LGBTQIA+ students within pre-registration midwifery education provide important insights on the preparation of kahu pōkai for culturally safe practice with LGBTQIA+ whānau. These insights are important because midwifery has committed itself to culturally safe practice with this population. Further, retaining and supporting LGBTQIA+ students ensures a diverse midwifery workforce reflecting the whānau we serve. However, no prior research has explored LGBTQIA+ midwifery student experiences.

Aim: To understand how pre-registration midwifery education in Aotearoa is experienced by LGBTQIA+ students.

Methods: Semi-structured qualitative interviews were undertaken with 12 LGBTQIA+ midwifery students and recent graduates about their experiences in pre-registration midwifery programmes in Aotearoa. Transcribed interviews were analysed using reflexive thematic analysis informed by critical realism and epistemic justice.

Results: Normative perinatal care and midwifery education environments present significant challenges and barriers to LGBTQIA+ midwifery student participation and success. LGBTQIA+ midwifery students experience both overt discrimination and erasure in clinical settings and lack opportunities to critically reflect on and integrate their experiences in theory-based learning.

Conclusions: Pre-registration midwifery education programmes need specific and dedicated strategies to facilitate LGBTQIA+ midwifery student participation and success. This will help ensure the diversity of the future midwifery workforce and that all future midwives are being prepared for culturally safe practice with LGBTQIA+ whānau.

Key message: Pre-registration midwifery education programmes need to build their capability for LGBTQIA+ student support and inclusion as part of an over-arching strategy to support a diverse midwifery workforce and culturally safe practice.

Stories of competence, challenges and coping: The experiences of Australian Autistic people during pregnancy and early parenthood

Abigail Love[B], Ru Ying Cai[B,C], **Bronwyn Rideout**[A,D], Linda Hollenberg[E], Gilly McKeown[F], Ainslie Robinson[B], Chris Edwards[B,G], Charlie Benzie[C], Vicki Gibbs[B,H]

[A] Presenting author: bronwyn.rideout@gmail.com
[B] Autism Spectrum Australia, Australia
[C] La Trobe University, Australia
[D] Te Herenga Waka | Victoria University of Wellington, Aotearoa NZ
[E] Reframing Autism, Australia
[F] Independent Autism researcher, Australia
[G] Griffith University, Australia
[H] University of Sydney, Australia

Background: Autistic adults face significant barriers accessing healthcare and frequently report negative experiences with practitioners. In Australia, approximately 9.5% of women of childbearing age have a disability, yet little is known about their pregnancy outcomes. Despite the importance of accessible perinatal care, research on the experiences of Autistic persons during pregnancy in Australia remains scarce.

Aim: The purpose of this study was to explore the pregnancy and early parenthood experiences of Australian Autistic individuals. This study provides insights that guide healthcare providers in offering individualised and effective perinatal care for Autistic women and persons.

Method: This study was co-designed with Autistic consumers and academics. Reflexive thematic analysis was conducted on 19 in-depth interviews with Autistic participants. Participants came from both rural and urban settings across Australia, identified as both female and non-binary, and shared a range of pregnancy experiences.

Findings: Four themes were generated. Theme 1, "I am competent", reflected feelings of capability during pregnancy. Participants expressed positive perceptions of their bodies and the social validation they received throughout the perinatal period. Theme 2, "Hyperfocus as an understatement", illustrates the participants' strong desire to do everything perfectly. They engaged in extensive research on every aspect of their pregnancy and parenthood journey. However, the impact on their wellbeing was varied. Theme 3, "I'm lost in the system", describes the negative impacts of increased social and healthcare interactions. Finally, Theme 4, "Making things work for me", addresses the coping mechanisms employed by participants to offset the emerging demands of pregnancy.

Conclusion: This study enhances understanding of the perinatal experiences of Autistic people, filling a critical gap in healthcare knowledge. These findings have broader implications for improving healthcare in other areas where Autistic people face similar challenges, emphasising the need for more inclusive and effective care to enhance quality of life.

Optimising induction of labour with oral misoprostol for women with a BMI ≥ 30 kg/m²: Foundations for a future clinical trial

Jenny Robb[A,B], Charlotte Oyston[B,C], Robin Cronin[B,C], Lynn Sadler[B,D]

[A] Presenting author: rejoice1001@gmail.com
[B] The University of Auckland | Waipapa Taumata Rau
[C] Te Whatu Ora | Health New Zealand – Counties Manukau
[D] Te Whatu Ora | Health New Zealand – Te Toka Tumai Auckland

Background: Oral misoprostol is commonly used for induction of labour (IOL) in Aotearoa New Zealand. Women with obesity (BMI ≥ 30 kg/m²) are more likely to require IOL and experience longer inductions and higher caesarean birth rates. Optimal misoprostol dosing for this population remains unclear.

Aim: To address this gap, this research compared IOL outcomes for women with varying BMI, and explored the acceptability of a future randomised controlled trial (RCT) comparing the standard 25 mcg misoprostol dose with higher doses for women with a BMI ≥ 30 kg/m².

Methods: Part 1 - A retrospective observational study compared misoprostol IOL outcomes between women with a BMI ≥ 30 kg/m² and < 30 kg/m². Primary outcomes included IOL-to-birth interval, number of misoprostol doses, and proportion of caesarean births.

Part 2 - A mixed-methods survey explored women's willingness to participate in a future IOL RCT and factors influencing acceptability. Reflexive thematic analysis was used for qualitative data.

Results: Part 1 - Among nulliparous women (n = 109), those with BMI ≥ 30 kg/m² (n = 62) had longer IOL-to-birth intervals and more misoprostol doses than those with BMI < 30 kg/m² (n = 47) (41.0 vs 22.6 hours, p = 0.0002; 11 vs 6 doses, p = 0.0001). Caesarean birth rates did not differ significantly between BMI groups (36% vs 26%, p = 0.2). Among multiparous women (n = 91), no significant differences in primary outcomes were observed between BMI groups.

Part 2 - Most (n = 47/51, 92%) survey participants expressed willingness to take part in the proposed IOL trial. Four themes influencing trial acceptability were identified: altruism, future IOL for self, safety, and unknowns of randomisation and blinding.

Conclusion: Differences in oral misoprostol IOL outcomes were observed between nulliparous women with varying BMI. Participants also expressed willingness to participate in a future trial. Together, these findings support the development of a RCT comparing different misoprostol doses for women with a BMI ≥ 30 kg/m².

Māori midwives, whānau and midwifery work: A relational perspective

Nimbus Staniland[A,B,] Kelly Tikao[C]

[A] Presenting author: Nimbus.staniland@auckland.ac.nz
[B] The University of Auckland | Waipapa Taumata Rau
[C] University of Otago | Ōtakou Whakaihu Waka

Background: Māori lead maternity care midwives (LMCs) play a critical role in supporting whānau through pregnancy, birth and beyond, often working across clinical, cultural and relational spaces. While there is growing attention to midwifery workforce wellbeing, less is known about how wellbeing is understood and experienced by Māori midwives and their whānau.

Aim: To explore how Māori midwives and their whānau conceptualise and navigate wellbeing in relation to midwifery work.

Method: This study is grounded in Kaupapa Māori and mana wāhine approaches, which guide the research design, relationships and interpretation. Qualitative data were generated through whakawhiti kōrero (in-depth conversations) and whānau wānanga with 12 Māori LMCs and their whānau. The research privileges relational engagement, collective reflection and participants' lived experiences.

Findings/Results: Analysis is currently underway. Initial engagement with the data suggests wellbeing may be understood in relational ways, connected to whānau, community and wider contexts of care. Participants share diverse experiences of midwifery work, with wellbeing shaped through relationships (whanaungatanga), the autonomy of LMC practice and the responsibilities that accompany this. Experiences vary across midwives and their whānau members, reflecting different contexts, roles and ways of engaging with the work. The presentation will explore these emerging insights and present findings following further analysis and engagement with participants.

Conclusion: This research contributes to conversations about midwifery wellbeing by centring Māori midwives and their whānau, and by exploring relational understandings of work and wellbeing. The findings aim to support more responsive and culturally grounded approaches to workforce wellbeing.

Evaluating GDM incidence with a rural lens: Insights from Te Tai Tokerau DOT Study

Naomi Waldron [A,B,C,] Helen Paterson[B,] Nicole McGrath[C,] Monique Williams[B,C,] Rosemary Hall[B,D,] Kirsten Coppell[B]

[A] Presenting author: naomi.waldron@otago.ac.nz
[B] University of Otago | Ōtakou Whakaihu Waka
[C] Te Whatu Ora | Health New Zealand – Te Tai Tokerau
[D] Health New Zealand | Te Whatu Ora – Capital, Coast and Hutt Valley

Background: Gestational diabetes mellitus (GDM) rates are increasing worldwide. The estimated global prevalence is 14%. The Delivering Optimal weighT gain advice in pregnancy (DOT) study in Te Tai Tokerau aims to improve health outcomes for māmā and pēpi through a midwife-delivered intervention that supports healthy gestational weight gain, thereby reducing GDM risk.

Aim: To describe GDM screening, incidence, management and birth outcomes in the DOT study cohort.

Method(s): Pregnant women aged > 18 years not requiring specialist referral at booking were recruited before 15 weeks' gestation. The first intervention visit was a separate appointment during the first trimester. The second and third intervention visits were delivered as part of routine antenatal visits at 4-weekly intervals. Data extracted from antenatal and hospital records included HbA1c, glucose challenge test (GCT) and oral glucose tolerance test (OGTT) results, GDM therapy, birth mode and birth outcomes. Data were analysed descriptively.

Results: Of 193 women recruited, 190 had a booking HbA1c recorded (range 23-46 mmol/mol). Of 171 women who did not miscarry, deliver or relocate from the region before recommended GDM screening at 24-28 weeks, 147 (86.5%) had a GCT, OGTT or both. Eleven of 147 (7.5%) had GDM (six multiparous, five primiparous). One relocated, six were managed through diet, two required metformin, two required combination metformin and insulin and one declined diabetes/obstetric input but continued LMC care. Among those who birthed in the region four had a NVD, three an elective C-Section, two an emergency C-Section and one forceps. Two babies were SGA and three LGA. Four babies had neonatal hypoglycaemia.

Conclusion: The proportion of women screened for GDM is higher than previously reported in Aotearoa New Zealand (NZ). Although there are no comparable NZ data, the impact of the DOT intervention on GDM rates is encouraging.

Virtual Reality and midwifery education

Melanie Welfare[A,B,C,] Susan Crowther[C,] Jane Frost[D]

[A] Presenting author: mpwelfare@hotmail.com
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau
[C] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[D] Western Sydney University, Australia

Background: Virtual Reality (VR) is increasingly used in midwifery education as part of the broader shift towards technology-enhanced learning. While enthusiasm for VR continues to grow, little is known about how students and educators actually experience this technology within undergraduate midwifery programmes. Understanding these experiences is essential for meaningful pedagogical integration.

Aim: To explore the experiences of midwifery lecturers and students who have engaged with a VR birthing scenario as a teaching and learning tool within their undergraduate education programme.

Method: Two hermeneutic phenomenological studies informed by Heidegger and Gadamer were brought together to deepen interpretive insight. Eight Bachelor of Midwifery students participated in individual interviews, and seven educators took part in focus groups. Transcripts were crafted into individual and collective stories, then

interpreted using Heideggerian concepts, Thrownness, The They, and Technology, along with Gadamerian notions of Spiel/Play and perception to support aletheia/unconcealment.

Findings: Two phenomena were revealed. Students described "Seen and Unseen pressures", showing how VR reality simultaneously supported skill development and exposed visible and hidden pressures embedded in midwifery education. Their accounts showed that immersive simulation heightened emotional awareness, influenced confidence, and drew attention to what is emphasised or overlooked in education. Educators articulated "Expert Lens versus Novice Wonder", demonstrating how professional identity shaped their interpretations of VR's realism and educational value. Experienced midwives evaluated VR against their embodied clinical expertise, whereas non-midwifery educators and students approached it with curiosity and openness.

Conclusion: VR was experienced as sufficiently "real", evoking authentic responses, yet its educational impact is dependent on thoughtful scaffolding and integration within education programmes. Its value lies not in replicating clinical reality but in creating a safe, interpretive space where learners explore their emerging ways-of-being.

Key message: VR becomes pedagogically powerful when understood as a relational, interpretive learning space shaped by expertise, perception and intentional facilitation.

THREE-MINUTE ORAL PRESENTATIONS + POSTERS

Improving post-partum analgesia for women: Introducing Methoxyflurane in the obstetric tertiary hospital setting

Karen Barnes[A,B], Nicola Delany[B]

[A] Presenting author: Karen.Barnes@TeWhatuOra.govt.nz
[B] Waikato Hospital

Background: There was recognition that routine analgesia options were likely lacking in efficacy or timeliness for acute post-partum procedures in the Delivery Suite (DS) and Women's Assessment Unit (WAU) at Waikato Hospital. Such procedures include removal of clots, removal of detached, but retained placentae, perineal inspection and suturing, and management of complex wounds. The use of methoxyflurane (Penthrox™) was piloted and audited amongst these patients in our institution.

Aim: To improve analgesia for women for acute post-partum procedures within DS and WAU at Waikato Hospital.

Methods: Methoxyflurane was rolled out for use in DS and WAU. Feedback forms were used to analyse efficacy, timeliness, ease of use, side effects, as well as staff and patient satisfaction.

Findings: Between October 2024 and March 2026, 51 feedback forms were received from participants and 57 feedback forms from staff. The feedback was largely positive from both participants and staff with 96% and 100% starting they would use it again, respectively. There were 92% of participants who rated the effectiveness of the analgesia as "excellent" or "good". There were 98% of staff who reported it was "easy" to educate the participant on methoxyflurane use with 98% of participants also rating its use as "easy". Although approximately half of participants and staff reported no side effects, there were some reports of mild to moderate side effects, most commonly being dizziness or light-headedness. There were 7% of staff who rated analgesia as "poor". There were 9% of participants who were transferred to theatre as their analgesia was inadequate or their clinical situation progressed to needing this. There were no adverse outcomes.

Discussion: Methoxyflurane for selected postpartum procedures is effective and well received by both participants and staff with a good safety profile.

Understanding whānau experiences of postnatal midwifery care: Early findings from the Birthing Whānau study

Shanti Daellenbach[B], Claire MacDonald[B], **Rea Daellenbach**[A,C], Jacqueline Martin[C], Amy Taylor[D], Talei Jackson[E], Annabel Farry[D], Violet Clapham[B], Shaqaiak Masomi[F], Shweta Kumar[G], Jay Waretini[C]

[A] Presenting author: rea.daellenbach@ara.ac.nz
[B] New Zealand College of Midwives
[C] Ara Institute of Canterbury | Ara Rau, Taumata Rau
[D] Otago Polytechnic | Te Kura Matatini ki Otago
[E] University of Waikato | Te Whare Wānanga o Waikato
[F] Health New Zealand | Te Whatu Ora – Te Toka Tumai Auckland
[G] LMC Midwife, Auckland

Background: Aotearoa is notable in offering a nationally funded, midwife-led continuity of care model that includes up to 6 weeks of postnatal care within professional and regulatory frameworks which express a commitment to give effect to Te Tiriti o Waitangi. While this model is internationally recognised as best practice, the postnatal period remains under-prioritised and under-researched. This includes how postnatal care in Aotearoa meets the needs of diverse birthing communities. There are also growing concerns around postnatal care access and fragmentation of care amid ongoing health sector reforms and workforce pressures.

Aim: To explore the experiences and expectations of mothers, parents, and whānau receiving postnatal care from LMC midwives in Aotearoa. To understand what people value about postnatal midwifery care and what contributes to positive postnatal experiences by working as Te Tiriti partners to demarginalise the voices of tangata whenua and diverse communities including Pacific, Indian, refugee, rural, LGBTQIA+, and disabled | tangata whaikaha whānau.

Methods: The study uses a pragmatic, person-oriented multiphase mixed-methods design which was stakeholder informed and embedded accessibility, inclusivity and cultural safety. In-depth interviews were undertaken with mothers and birthing parents who had received LMC postnatal care within the previous two years. A whānau interview approach enabled participants to include whānau members or take part in wānanga-style discussions. Features of the study included easy-to-read plain language resources, inclusive and affirming language, flexible participant-led interview options, trauma-informed methodologies, and practising continuous consent. Interview transcripts were analysed using Reflexive Thematic Analysis.

Findings: This study is ongoing at the time of writing. Early findings from the analysis will be presented, highlighting key themes drawn from participants' accounts of their postnatal LMC midwifery care, including what people from diverse birthing communities valued in their care, the support they expected during the postnatal period, and factors that shaped their postnatal experiences.

Exploring Māori and non-Māori women's perspectives on early medical abortion follow-up methods

Yasmina Daskapan[A,B], Teena Gamage[B], Sophia Amjad[B], Varsha Parag[B], E. Jane MacDonald[C], Michelle Wise[B]

[A] Presenting author: yasmina.das23@gmail.com
[B] The University of Auckland | Waipapa Taumata Rau
[C] Victoria University of Wellington

Background: Early medical abortion (EMA) is now within the midwifery scope of practice. The Mate Whenua randomised control trial compared self-assessment with an at-home low-sensitivity urine pregnancy test (UPT) to clinic-based comparative blood tests (CBT) to confirm complete EMA. Although both methods are supported for EMA follow-up in Aotearoa, their acceptability for Māori and non-Māori women has not been established.

Aim: To assess whether Māori and non-Māori participants differed in their preferred follow-up method for a future EMA.

Methods: This is a secondary analysis of the Mate Whenua trial data (ethics approval: Northern B Health and Disability Ethics Committee, #13189, ACTRN12623000890639). Quantitative and thematic analyses examined participant survey responses four-weeks post-EMA, categorised by follow-up method (UPT or CBT) and ethnicity (Māori and non-Māori).

Results: Of the 732 participants, 251 (34%) returned the survey: Māori comprised 48/133 (36%) randomised to the UPT group and 27/118 (23%) to the CBT group. No differences were found between Māori and non-Māori women in preferred follow-up method, satisfaction, acceptability, understanding of results, or disappointment in the time to exclude ongoing pregnancy ($p > 0.05$). Non-Māori were more likely to prefer the UPT over CBT ($p = 0.03$), while Māori showed no difference in preference ($p > 0.05$). Qualitative findings indicated that the UPT was valued for privacy, discretion, convenience and reduced anxiety, whereas the CBT was trusted for its simplicity and earlier confirmation of EMA success. Both groups reported concerns about limited follow up, access to support, test accuracy, and practical or emotional drawbacks.

Conclusion: Both EMA follow-up methods were highly acceptable for Māori and non-Māori women. Future research powered for ethnicity-specific comparisons is needed. Current findings support offering both UPT and CBT follow-up methods in Aotearoa to promote equity and cultural safety.

Acknowledgement: The authors would like to acknowledge Iwi United Engaged Ltd (Misty, Stephanie, Langi and Ben) for their contribution to the design of the trial, survey questions and participant-facing resources.

Experiences of wāhine hapū (pregnant women) with oral health care in Aotearoa, New Zealand

Linda Elvines[A,B], Robyn Maude[B], Susan Crowther[C], Fran Kewene[B]

[A] Presenting author: lelvines24@gmail.com
[B] Te Herenga Waka | Victoria University of Wellington
[C] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: Oral health during pregnancy is increasingly being recognised as an important component of maternal and infant wellbeing. Poor oral health is associated with periodontal disease, infection, and adverse pregnancy outcomes. Despite this growing recognition, engagement with oral health services during pregnancy remains inconsistent. In Aotearoa New Zealand, wāhine Māori continue to experience significant inequities in oral health outcomes and access to dental care, reflecting the enduring impacts of colonisation and systemic barriers within health services. Midwives are often the primary health professionals supporting wāhine during pregnancy and are therefore well positioned to promote oral health awareness and facilitate access to care.

Aim: This study explores the experiences of wāhine Māori and their whānau engaging with oral health care during pregnancy and up to 3 years postnatally. The research seeks to understand the barriers, enablers and broader systemic influences shaping engagement with oral health services throughout the perinatal journey.

Methods: A Kaupapa Māori methodological approach that centres Māori knowledge, values and aspirations throughout the research process was used. Guided by principles aligned with Te Tiriti o Waitangi, the research is privileging the voices and lived experiences of wāhine Māori and their whānau. Interpretive Description is used as a complementary qualitative methodology to support the interpretation of experiential narratives and the development of practice-relevant knowledge in maternity and oral health care.

Findings/Results: Data collection and analysis are currently underway. It is anticipated that the research will identify structural, social and cultural factors influencing engagement with oral health services and highlight opportunities to strengthen culturally responsive care.

Conclusion: By centring the lived experiences of wāhine Māori, this research contributes to a deeper understanding of oral health care during the perinatal period and informs more equitable and culturally responsive maternity and oral health services.

Exploring the impact of undergraduate experience of homebirth on early midwifery practice

Gwendoline Glazzard[A,B,C]

[A] Presenting author: gwendoline.glazzard@ara.ac.nz
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau
[C] Otago Polytechnic | Te Kura Matatini ki Otago

Background: Current concerns with rising intervention rates and declining normal physiological birth highlights the importance of quality midwifery education that will enable and prepare midwives in Aotearoa to step into practice with confidence to support physiological birth in any setting. Undergraduate midwifery clinical placements overseas are largely based in obstetric led units exposing students to medicalised births and raising concerns that this experience doesn't equip midwives with the skills and experience to facilitate birth in a primary setting.

Aim: To explore how pre-registration experience of homebirth influences early midwifery practice.

Objectives: To identify the incidence and breadth of home birth exposure new practitioners experienced during their undergraduate education; to explore how new practitioners' experience of home birth may have influenced their midwifery philosophy or confidence in providing home birth services.

Method: The study is a mixed methods design incorporating online survey, followed by semi-structured interviews. Quantitative

data from the surveys will be analysed descriptively followed by thematic analysis of the qualitative data.

Findings: This is a Master's project and I do not have preliminary findings yet. When the data collection and analysis is complete these findings will highlight the Aotearoa perspective that will complement or contrast with the overseas research.

Conclusion: This will be dependent on the thematic analysis; however, I have included the key message currently based on the literature review which is largely from overseas research.

Key message: Highlighting the unique nature of undergraduate ākonga/ student placements in Aotearoa, and the importance of protecting this, is similar to the challenge of protecting our model of care. Research from overseas shows the value of continuity of care placements and home birth experience in developing practitioner confidence and midwifery philosophy, as opposed to the more task-focused experience of placements that mainly take place in obstetric-led hospital settings.

Patterns of gestational weight gain in the Delivering Optimal weighT gain advice in pregnancy (DOT) case study in Te Tai Tokerau, Aotearoa New Zealand

Helen Paterson[A,B] Naomi Waldron[B] Monique Williams[B] Mel Rackham[C] Sarah Donald[B] Katrina Sharples[B] Rosemary Hall[B] Nicole McGrath[D] Beverley Lawton[E] Kirsten Coppell[B]

[A] Presenting author: helen.paterson@otago.ac.nz
[B] University of Otago | Ōtakou Whakaihu Waka
[C] Te Whatu Ora | Health New Zealand – Southern
[D] Health New Zealand | Te Whatu Ora – Te Tai Tokerau
[E] Victoria University of Wellington | Te Herenga Waka

Background: Excess weight gain in pregnancy occurs in up to 70% of wāhine who birth. Although wāhine with a healthy weight or who are underweight pre-pregnancy can have excessive gestational weight gain (GWG), most intervention studies only include overweight/obese participants. The Delivering Optimal weighT gain advice in pregnancy (DOT) study recruited wāhine irrespective of their pre-pregnancy body mass index (BMI).

Aim: The aim of this study was to describe GWG patterns by BMI category among DOT study participants.

Methods: This Te Tai Tokerau-based case study trained LMC midwives to deliver the DOT intervention. They recruited pregnant wāhine aged ≥ 18 years who registered at < 15 weeks gestation and did not have a pre-existing health condition(s) requiring specialist obstetric or dietetic care at booking. The intervention was delivered at three time points during the first and second trimesters: the first before 15 weeks' gestation then the next two at 3-4 weekly intervals. LMC midwives were provided with calibrated weighing scales and a stadiometer. They were encouraged to weigh participants at each antenatal visit and the 6-week postnatal visit. Pre-pregnancy BMI (kg/m^2) was calculated using the first antenatal weight (kg) and height (m), then participants were categorised into three groups – healthy weight, overweight, obese. Gestational weights were plotted for each participant, and median weight gain was calculated for each group.

Results: Seventeen LMC midwives recruited 193 participants of whom 164 did not miscarry or transfer to a non-study LMC and birthed in the study region. All participants had a measured height and weight at their registration visit. Among these 164 participants, 63 (38.4%) had a healthy BMI, 45 (27.4%) were overweight and 56 (34.1%) were obese. Weight gain patterns and median GWG by BMI category are being calculated and will be presented.

Conclusion: Monitoring GWG throughout pregnancy is important irrespective of pre-pregnancy BMI.

Va'a o Nga Wāhine (One Waka, Many Voices)

Janet Taiatini[A,B,C] Peace Te Kani[C,D] Melissa Henry[E,F]

[A] Presenting author: janet.taiatini@wintec.ac.nz
[B] Registered Midwife – Te Whatu Ora | Health New Zealand – Lakes
[C] Te Ara o Hine Liaison – Wintec
[D] Registered Midwife – Waterford Birth Centre
[E] Registered Midwife – Te Whatu Ora | Health New Zealand – Waikato
[F] Tapu Ora Liaison – Wintec

Background: Aotearoa New Zealand has five midwifery schools providing a four-year, full time undergraduate Bachelor of Midwifery. Each curriculum aligns with Te Tatau o Te Whare Kahu | Midwifery Council Standards of Competence and supports the readiness of tauira (students) for sitting the national exam and gaining midwifery registration.

Maaori and Pasifika whānau are approximately 48%, as at June 2025, of the birthing community and display the most significant health inequities in our nation.

Aotearoa has a significant shortage of Maaori and Pasifika midwives, who together make up only 11.4% of the midwifery workforce. To provide maternity care that truly meets the clinical and cultural needs of these whaanau, we need to grow this workforce.

Te Ara o Hine Tapu Ora (TAOHTO) commenced in 2021 to address the inequity existing in education streams for Maaori and Pasifika seeking education and registration as midwives. Te Ara o Hine Tapu Ora is funded by Whatu Ora to increase recruitment of Maaori and Pasifika tauira, maintain numbers, and reduce attrition in midwifery programmes.

Aim: CHASP (Centre of Health and Social Practice) TAOHTO team at Wintec are exploring the experiences of tauira who have successfully completed the degree and gained midwifery registration whilst being supported in the TAOHTO programme.

Method: Using Kaupapa Maaori methodology we will explore the influence and factors contributing to the programme's success. Open ended questions will facilitate focus group koorero (dialogue) to expose the congruent way our people relate to each other in collaborative spaces.

Discussion: It is anticipated the study's findings will influence curriculum design and teaching practices within the midwifery programme for the future.

Enabling connection: Midwives' experiences with using communication technology with their pregnant clients

Karen Wakelin[A,B] Judith McAra-Couper[C], Tania Fleming[C]

[A] Presenting author: karen.wakelin@op.ac.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago
[C] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: Use of communication technology particularly asynchronous communication within maternity care is an efficient and convenient way for pregnant women/people to access their midwife. This is enabled through texting, emailing and the sharing of information via electronic means. What is less clear, is how these connections have contributed towards quality maternal and newborn care.

Aim/Objectives: To highlight how communication technology can be used in enabling midwives and pregnant people to connect.

Method: This study reports on the findings from Phase 2A of a mixed method multi-phase sequential transformative design. In phase 2A, data was collected via online face-to-face interviews with 14 LMC midwives using the online platform Microsoft Teams. Results were analysed using thematic analysis.

Findings/Results: Enabling connection was one of three findings from interviews conducted with LMC midwives. Use of communication technology enabled connection between LMC midwives and their pregnant clients in two ways. Firstly, through giving space, and secondly through flexibility and convenience of the technology in supporting midwives and pregnant women/people to connect. Asynchronous communication such as text and email was integral in providing this space for messages to be read and considered before being responded to. It also offered space for people to connect and ask questions that they may not feel comfortable asking face to face. The flexibility and convenience of the technology offered innovative and flexible ways to assist with connections, sharing of information to inform decision making, and ensuring access to safe care.

Conclusion: The midwives in this study highlighted the innovative and flexible ways that communication technology can be used in enabling connections with pregnant women/people and thus contributing towards quality care.

Midwives as navigators - an appreciative inquiry into the work of hospital midwives in New Zealand

Tracy Walker[A,B], Andrea Gilkison[B], Jo Egan[B], Christine Mellor[B]

[A] Presenting author: tracyannwalker4@yahoo.co.nz
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

This doctoral study asks the question: What is the work of core midwives and what facilitates their role in New Zealand's large hospitals? Core midwives, a term specific to New Zealand for employed hospital midwives, are described as integral to or the "backbone of New Zealand maternity service". The 2024 Midwifery Workforce Survey conducted by the New Zealand Midwifery Council highlighted this pivotal role with 48.1% (1,618/3,364) of midwives identifying core midwifery as their main source of work. This compares with 32.6% (1,095/3,364) of midwives identifying caseloading as their primary role, which includes both employed and self-employed as lead maternity carers (community caseloading midwives). Despite their unique contribution to the midwifery profession, core midwives perceived themselves as 'just a core midwife' and feel as 'invisible'. These perceptions warrant exploration and comprehension of the work and role of core hospital midwives.

This appreciative inquiry study, with a hermeneutics lens, explores the everyday work of core midwives within New Zealand's large secondary/tertiary hospitals, and what facilitates their role. Fourteen core midwives from New Zealand participated. The study found that core midwives could be described as 'navigators'. Midwives in this study described their unique skillset which enabled them to work in partnership with the women in their care and navigate the often-complex care that women required. To be an effective navigator, the core midwife needs to be able to communicate well with women and their families, cultivate effective collegial relationships, and foster teamwork.

This research is important because it brings perspective to the significant role that core midwives play, enriching understandings of maternity care provision and acknowledging the support for safeguarding core midwives' well-being who, at their 'core', safeguard the lives of women and their babies.

Midwives' and ambulance personnel's experiences of working together: A scoping review of qualitative evidence

Nimisha Waller[A,B], Renee Taylor[B], Anna Fielder[B]

[A] Presenting author: nimisha.waller@aut.ac.nz
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: In 2022 the Midwifery Council and Paramedic Council of New Zealand jointly affirmed their commitment to collaboration and professional relationships. Integral to prioritising the health and safety of the public by ensuring competent practice, they also emphasised the importance of interdisciplinary collaboration in providing safe and effective care. Paramedics respond to a wide variety of clinical presentations and are essential in providing care with midwives to birthing people and/or for neonatal emergencies. In 2024 Hato Hone St John responded to 2,745 (0.86%) obstetric-related conditions. How midwives and paramedics work together during these emergencies is not well documented or understood. The scoping review aimed to identify what is known from existing literature about midwives and paramedics working together, and to illuminate existing knowledge gaps in the literature.

Aim: To identify what is known, from research about midwives' and ambulance personnel's experiences of working together.

Methods: The Joanna Briggs Institute (JBI) methodology for conducting scoping reviews that contains nine steps was used. The Preferred Reporting Items for Systematic Reviews was followed in accordance with JBI methods for reporting scoping reviews. Five databases were searched: CINAHL Complete (via EBSCO), MEDLINE (via EBSCO), Ovid Emcare, MIDIRS (via OVID) & AUT Google Scholar. Joanna Briggs Institute Qualitative data extraction tool was used to extract the data. The extracted data was synthesised using thematic analysis.

Findings: Six themes were identified: importance of environment; scope, roles and responsibilities; team dynamics & interactions; accessibility challenges, cultural shame & psychological impact.

Conclusion: Despite potential challenges, midwives and ambulance personnel have a desire to provide a safe and positive experience for women/pregnant people and whānau. Interprofessional education has the potential to foster understanding of roles and responsibilities, enhance communication and improve collaborative practice during and at the time of admission of pre-hospital emergencies.

Evaluating the Maternity Care Assistant role across Aotearoa New Zealand: Insights from midwifery stakeholders

Caitlin Woods[A,B], Robin Cronin[C], Stephanie Shankar[D], Shekinah Gafa[C], Vanessa Jordan[E], Katie Groom[B,F]

[A] Presenting author: caitlin.woods@auckland.ac.nz
[B] Liggins Institute, The University of Auckland | Waipapa Taumata Rau
[C] Te Whatu Ora | Health New Zealand – Counties Manukau
[D] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[E] The University of Auckland | Waipapa Taumata Rau
[F] Te Whatu Ora | Health New Zealand – Te Toka Tumai Auckland

Background: Strengthening the midwifery workforce is a national priority in Aotearoa New Zealand. The Maternity Care Assistant (MCA) role was introduced during the COVID-19 pandemic as a paid employment model for Bachelor of Midwifery students to support maternity services. Emerging evidence suggests it may enhance students' confidence, sense of belonging, and transition into practice, however, regional variation, differing expectations, and an unclear scope of practice highlight the need for further evaluation.

Aim: To examine the current use of the MCA role across Aotearoa New Zealand and explore key midwifery stakeholder perspectives on the future of the MCA model.

Methods: This observational mixed-methods study included a document review and semi-structured interviews. Quantitative data from available regional MCA position descriptions were used to map role scope and employment characteristics. Qualitative data were collected through interviews with purposefully selected midwifery stakeholders from Te Whatu Ora leadership, midwifery education providers, and national midwifery organisations. Interviews explored experiences of the introduction of the MCA role, perceived variation in practice, and views on future directions for the model. Data were analysed using thematic analysis.

Findings: Eighteen interviews were conducted with midwifery stakeholders. Participants described the regional development and current use of the MCA role, reflected on perceived impacts for services, education, and workforce development. Participants also identified opportunities to strengthen the MCA model, including considerations for Māori and Pacific students. Thematic analysis of findings will be presented. Document reviews of MCA position descriptions will complement results by mapping formal role scope and expectations across regions.

Conclusion: These findings will clarify current application and variation of the MCA role and contribute to national discussions about future workforce planning and paid student employment models within midwifery in Aotearoa New Zealand.

BREAKFAST SESSION

Squeezing pregnant bodies into a business model of compensation: Exploration of the contradictions of LMC midwives' work structure

James Greenslade-Yeats[A,B], Tago Mharapara[B], Janine Clemons[B], Katherine Ravenswood[B]

[A] Presenting author: james.greenslade-yeats@aut.ac.nz
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: Aotearoa New Zealand is known for its midwife-led maternity care system that enables continuity-of-care throughout the perinatal period. Known as lead maternity care (LMC) midwifery, this care model affords midwives a unique level of work autonomy with respect to care provision. However, LMC midwives' autonomy is structured within a "business model" of compensation, whereby midwives are paid in discrete care modules, cover their own business expenses, and forego the rights and entitlements of structured employment.

Aim: The aim of this research is to explore conflicts and contradictions arising from the structuring of midwives' autonomy within a business model of compensation.

Method: We conducted joint family interviews involving current or former LMC midwives (n = 47) and nominated members of midwives' own families (n = 51). We analysed interviews through template analysis – a structured form of thematic analysis.

Findings: We developed three key themes relating to contradictions between LMC midwives' autonomy and the business model of compensation. (1) The absence of organisational structure does not necessarily increase LMC midwives' control over when, where, and how they work. (2) LMC midwives' autonomy is meant to accommodate the organic rhythms of the pregnant body, but the business model of compensation ignores the inherent flexibility required to accommodate these rhythms. (3) LMC midwives' autonomy is intended to enable continuity of care, yet the modular payment schedule can promote fragmented care.

Conclusion: Our research raises important questions about discrepancies between the intentions behind the autonomous LMC midwifery care model and how the model plays out in practice. We provide insights into how certain elements of the model could be re-structured to ensure the costs of these discrepancies are not borne disproportionately by midwives and their own families.

"The soundtrack of our lives": Unpacking the hidden cost of constant connectivity for LMCs and their families

Tago L. Mharapara[A,B], James Greenslade-Yeats[B], Katherine Ravenswood[B], Janine Clemons[B]

[A] Presenting author: tago.mharapara@aut.ac.nz
[B] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau

Background: Information and communication technologies (ICTs), including laptops, tablets and smartphones, allow people to work remotely, flexibly and autonomously. In midwifery, ICTs have been shown to strengthen midwife-client relationships and improve the documentation of care. Likewise, clients report feeling known, having better access and connectedness, and benefiting from the ability to communicate with midwives in their own time. However, modern ICTs have been linked to heightened expectations of availability, escalating engagement and difficulties disconnecting from work. Midwifery research specifically highlights challenges to work-life balance, and blurred expectations around urgent versus non-urgent communication from clients.

Aim: Our study aimed to understand how constant connectivity with ICTs impacts caseloading LMCs and their family members.

Method: We conducted 47 joint family interviews with 98 participants (47 LMCs and 51 family members). LMCs participated in joint family interviews alongside one or more self-nominated family members (e.g., partner, child). We analysed interviews through template analysis – a structured form of thematic analysis.

Findings: From the data, we developed a detailed understanding of a phenomenon we label techno-home invasion. This phenomenon occurs when work-related ICTs, especially smartphones, are perceived as disruptive and inescapable. Smartphones 1) disrupt core routines (i.e., sleep, meals, childcare), 2) tether family activities to areas with cell coverage, and 3) foster anticipatory anxiety even when they do not ring or vibrate. Over time, smartphones become flashpoints for resentment and conflict, straining family relationships.

Conclusion: While midwifery research shows that multiple contact routes help clients reach their midwife and support continuity of care, our data show that round-the-clock reachability can also drive techno-home invasion – disrupting rest, recuperation and family life.

Key message: The negative impact of constant reachability on midwives and their families is a key factor that needs to be considered in funding, regulatory and policy levers.

Paid student employment models in midwifery, nursing and allied health: A systematic review

Caitlin Woods[A,B] Stephanie Shankar[C] Aishwarya Joshi[D] Vanessa Jordan[E] Robin Cronin[F] Katie Groom[B,D]

[A] Presenting author: caitlin.woods@auckland.ac.nz
[B] Liggins Institute, The University of Auckland | Waipapa Taumata Rau
[C] Auckland University of Technology | Te Wānanga Aronui o Tāmaki Makau Rau
[D] Te Whatu Ora | Health New Zealand – Te Toka Tumai Auckland
[E] The University of Auckland | Waipapa Taumata Rau
[F] Te Whatu Ora | Health New Zealand – Counties Manukau

Background: Global health systems continue to face workforce shortages, high student attrition and underrepresentation of Indigenous health workers. Paid student employment models have emerged as a potential strategy to strengthen service delivery while providing students with additional clinical experience. These models are increasingly used across midwifery, nursing and allied health, yet their impact on student outcomes and the health workforce remains unclear.

Aim: To assess the effectiveness of paid student employment models in midwifery, nursing and allied health.

Methods: This systematic review, registered with PROSPERO (CRD420251070851), searched CENTRAL, MEDLINE, CINAHL, Embase and Google Scholar for quantitative studies (2005 - present) examining paid student employment models within or alongside education programmes. Screening was completed in Covidence, with quality appraised using ROBINS-I V2 and certainty of evidence assessed with GRADE. Primary outcomes include student performance, workforce readiness and retention.

Results: Database searches identified 8,338 records. After removing duplicates (n = 1,592), 6,746 titles and abstracts were screened, 85 full texts reviewed and 29 studies included. Most studies were conducted in the United States (n = 13) or Australia (n = 11) and focused on nursing (n = 22), with fewer examining midwifery (n = 5) or pharmacy (n = 2). The majority were observational designs. Only 10 studies included comparison groups or pre/post data, and overall methodological quality was limited. Reported outcomes commonly indicated improved student performance, workforce readiness and retention associated with paid employment, including a statistically significant improvement in readiness among nursing students ($p < 0.001$). Ethnicity and equity-focused outcomes were rarely reported, and evidence for organisational and economic well-being was limited.

Conclusion: Paid student employment models may enhance workforce readiness, particularly within nursing, but evidence for midwifery and allied health remains limited. Overall, the current evidence base needs further comparative studies to clarify impacts across professions.

POSTER PRESENTATIONS

Māori sleep health: Scoping review

Sally Baddock [A,B] Angela Campbell[C] Rachelle Love[D] Sarah-Jane Paine[E]

[A] Presenting author: sally.baddock@op.ac.nz
[B] Otago Polytechnic | Te Kura Matatini ki Otago
[C] University of Otago | Ōtakou Whakaihu Waka
[D] Te Whatu Ora | Health New Zealand – Waitaha Canterbury
[E] The University of Auckland | Waipapa Taumata Rau

Background: Indigenous communities globally experience poorer health outcomes in comparison to non-Indigenous people, and health inequities impact sleep health. Such health inequities exist for Māori in Aotearoa and lead to poorer sleep health for pregnant people and infants.

Aim: This study aimed to collate and summarise the peer reviewed literature on Māori sleep health to provide an understanding of where equity gaps lie and to inform policy and target further research.

Methods: A broad systematic search of widely used research databases was conducted using keywords: "sleep", "insomnia", "sleep initiation and maintenance disorders", combined with "Māori", "New Zealand" or "Oceanic Ancestry Group". Studies that provided sleep health measures for Māori versus non-Māori were included. Sleep data summaries were presented for each life stage including during pregnancy and infancy.

Results: A total of 1052 records were scrutinised against inclusion criteria, with 87 meeting the criteria. Data collection measures were mostly self or parental-report, utilising validated questionnaires. Inequities in sleep health between Māori and non-Māori were identified across all life stages, beginning with increased risk of sudden unexpected death in infancy, and including poorer sleep health for Māori during pregnancy. Socio-economic deprivation and unemployment were associated with poorer sleep health outcomes.

Conclusion: Evidence from Aotearoa clearly shows that Māori experience significant inequities in sleep health, with strong links to socioeconomic deprivation. We conclude that a public health policy for sleep that prioritises Māori and targets long-term, sustainable achievement of sleep health equity goals, as part of a broader commitment to health equity, is required. Future sleep health research should aim to involve Māori at all stages.

Key message: Māori experience poorer sleep health across the lifespan, including during infancy and the perinatal period, that is associated with the impact of social determinants of health such as socioeconomic deprivation.

Hapūtanga Wānanga: Find your Wānanga

Kimberley Caradus[A,B] April Irwin[B]

[A] Presenting author: dkcaradus@gmail.com
[B] University of Waikato | Te Whare Wānanga o Waikato

Background: Perinatal health inequities in Aotearoa New Zealand begin early and disproportionately affect Māori whānau. Antenatal education has potential to improve knowledge, engagement and health outcomes; however, participation in mainstream childbirth education remains uneven. Hapūtanga wānanga and other culturally relevant antenatal education models may offer a more acceptable and effective approach for hapū Māori by aligning education with tikanga, whānau-centred practice and community needs.

Aim: This literature review explored what current research reveals about participation in hapūtanga wānanga or culturally relevant antenatal education, and examined its impact on barriers, health inequities and outcomes for hapū Māori.

Method: A focused literature review was undertaken using Aotearoa New Zealand literature, including national reports, Māori health data and peer-reviewed research. The review examined three key themes: engagement with available perinatal services, barriers to antenatal education, and cultural safety in antenatal education delivery.

Findings: The review identified lower participation in mainstream antenatal education among Māori, Pasifika, younger parents and disabled parents. Reported barriers included cost, transport, scheduling, childcare, lack of awareness and reduced engagement with maternity services. The literature also highlighted wider structural issues, including colonisation, socioeconomic deprivation, and services that do not adequately reflect Māori

values and lived realities. In contrast, qualitative findings suggest that local, community-based and culturally grounded approaches such as hapū wānanga are more likely to be valued, accepted and completed. These models may improve cultural safety, reduce barriers and strengthen whānau engagement, although robust national outcome data remains limited.

Conclusion: Culturally grounded antenatal education is an important equity strategy, not an optional add-on. Hapūtanga wānanga show strong promise for reducing barriers and supporting better perinatal engagement and outcomes for Māori whānau. Further research is needed to strengthen the evidence base.

Acceptability, accessibility and key outcomes of the Delivering Optimal weighT gain advice in pregnancy (DOT) case study in Te Tai Tokerau, Aotearoa New Zealand

Kirsten Coppell[A,B], Naomi Waldron[B,C], Monique Williams[B,C], Nicole McGrath[C], Beverley Lawton[D], Mel Rackham[E], Katrina Sharples[B], Sarah Donald[B], Rosemary Hall[B,F], Trudy Sullivan[B], Helen Paterson[B]

[A] Presenting author: kirsten.coppell@otago.ac.nz
[B] University of Otago | Ōtakou Whakaihu Waka
[C] Te Whatu Ora| Health New Zealand - Te Tai Tokerau
[D] Victoria University of Wellington | Te Herenga Waka
[E] Te Whatu Ora | Health New Zealand – Southern
[F] Te Whatu Ora | Health New Zealand – Capital, Coast and Hutt Valley

Background: Up to 70% of women who birth gain more weight than recommended. Antenatal lifestyle interventions can limit excess gestational weight gain (GWG). However, translation into routine midwifery antenatal care is uncommon.

Objectives: The Delivering Optimal weighT gain advice in pregnancy (DOT) study aims to determine whether a midwife-delivered healthy food choice intervention is acceptable to midwives, acceptable and accessible to pregnant wāhine, leads to improved pregnancy outcomes and reduces health inequities for Māori. This presentation describes key study outcomes.

Methods: This Te Tai Tokerau-based case study trained LMC midwives to deliver the DOT intervention. They invited pregnant wāhine aged ≥ 18 years who registered at < 15 weeks' gestation and did not have a pre-existing health condition(s) requiring specialist obstetric or dietetic care at booking. There were three intervention visits, the first a separate visit before 15 weeks' gestation, then two at 3-4 weekly intervals as part of routine visits. Weight measures at each antenatal visit and the 6-week postnatal visit were encouraged. Routinely recorded clinical data, including demographics, anthropometry, blood pressure, HbA1c and delivery details, were collated. Proportions and means were calculated.

Results: Seventeen LMC midwives, who remained actively engaged throughout the study, recruited 193 participants, of whom six (3.1%) moved location, three (1.0%) transferred to a non-study LMC, 19 (9.8%) miscarried and two (1%) withdrew – both reported being too busy. Three intervention visits were completed by 165 participants, including three who miscarried, two who moved location and one who transferred to another LMC. Of those who completed the study and delivered in the region, one completed two intervention visits and four completed the first intervention visit only. Achievement of recommended GWG will be presented.

Conclusion: Study retention and intervention completion by both midwives and participants were high.

Key message: Study results will inform midwife-delivered healthy GWG guidance and support.

Shaping inclusive foundations: South and Southeast Asian student perspectives on health equity education

Ashly Mangalasseril[B], **Junee Ly**[A,B], Anna Tiatia Fa'atoese Latu[B], Talei Jackson[B]

[A] Presenting author: junee.ly@waikato.ac.nz
[B] University of Waikato | Te Whare Wānanga o Waikato

Background: Understanding the specific health needs of South and Southeast Asian communities is essential to delivering maternity care that women value, trust, and wish to receive. These communities hold diverse health worldviews that differ from Western, Māori, or Pacific models. In some Asian cultural contexts, healthcare interactions are perceived as transactional, with expectations that health professionals provide direct instruction rather than shared decision making. Combined with systemic barriers -– such as limited linguistic access, unfamiliarity with Aotearoa's maternity system, and under representation of Asian-specific health issues – these factors may contribute to persistent inequities. With Aotearoa's growing Indian and Asian populations, particularly in the Waikato region, health education must respond to these demographic shifts.

Aims: To explore how Asian health needs are addressed within health professional education and whether learning environments are culturally safe and inclusive for South and Southeast Asian students.

Methods: This study was situated within the University of Waikato's Division of Health and used a qualitative-informed approach. Data were collected through an online survey using targeted recruitment strategies. Reflexive analysis was undertaken to examine both participant responses and patterns of non-engagement.

Findings: Responses from three Asian-born students indicated high satisfaction with cultural safety and lecturer support. However, perceptions were mixed regarding cultural representation in case studies, comfort sharing cultural perspectives, and the relevance of health equity content to their own communities. Reflection on the low response rate suggests that timing, minority pressures, cultural deference to authority, and concerns about speaking out may contribute to participant silence.

Conclusion: Silence itself offers insight into the structural and cultural dynamics shaping student engagement and highlights the need for intentional approaches to Asian health equity in education.

Key message: For midwives, meaningful health equity education must reflect all communities.

Midwifery reflection in Aotearoa New Zealand: A scoping review

Morag MacAulay[A,B], Suzanne Miller[C], Annabel Farry[C], Rea Daellenbach[B]

[A] Presenting author: mmacaulay010@gmail.com
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau
[C] Otago Polytechnic | Te Kura Matatini ki Otago

Background: Midwives in Aotearoa New Zealand are expected to be reflective practitioners. Reflection is integral to culturally safe practice and supports midwives to be Te Tiriti o Waitangi partners. It is embedded in the Tūranga Kaupapa education update, and required by Te Tatau o te Whare Kahu | Midwifery Council Standards of Competence. Midwives are asked to reflect following professional development activities.

Aims: This scoping review sought to identify what is known about midwifery reflection in Aotearoa, how midwives engage in reflective processes, and how reflection contributes to practice development and improved outcomes for whānau.

Method: A scoping review was conducted using key terms such as 'midwifery', 'reflect', 'Aotearoa New Zealand', and 'debrief' across three databases. Search terms were broadened to include wider midwifery contexts and Indigenous models of reflexive practice. Quality assessment of the retrieved literature resulted in the inclusion of 21 studies relevant to midwifery reflection in Aotearoa.

Findings: Analysis revealed themes along the journeys of midwives in Aotearoa. Reflection is well established within undergraduate midwifery education and shown to enhance learning. The midwifery First Year of Practice mentoring programme supports mentees through structured reflection. Evidence indicates that established midwives value intentional reflection time and desire greater support when processing challenging or emotionally complex experiences. However, there is limited research describing how midwives in Aotearoa undertake reflection or whether it effects change in practice.

Conclusion: Understanding how midwives reflect on their practice is valuable. This review highlights gaps in knowledge and provides justification for ongoing research in this important area of midwifery practice.

Key message: Gaining further insight into midwifery reflective practice may offer pathways to strengthening this behaviour within the workforce.

Gaps in culturally responsive care: Reweaving Indigenous fathers into the birthing space

Karaena Vincent[A,B], Jazmin Jones[B], Nathalie Gee[B], Jacqueline Martin[B]

[A] Presenting author: info@birthstory.co.nz
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau

Background: In Aotearoa, midwifery care increasingly recognises whānau as central to wellbeing, yet Indigenous fathers remain largely invisible in maternity research and practice. Colonisation disrupted the traditional roles of tāne as kaitiaki, providers and nurturers, replacing them with stereotypes of absence and marginalisation. Addressing this gap is essential for culturally responsive, equitable care.

Aim: To critically evaluate qualitative research on Indigenous fathers' experiences across the pregnancy continuum and identify implications for midwifery practice in Aotearoa.

Method: A comprehensive literature search was conducted using Ara Library Primo, Google Scholar, ProQuest and CINAHL Ultimate. Fifteen studies were identified using search terms including Indigenous fathers in pregnancy and birth, tāne Māori in hapūtanga, and Māori fathers' roles in pregnancy. Three met the inclusion criteria. Selected studies employed culturally grounded methodologies: yarning, photovoice, and wānanga with pūrākau.

Findings: Three cross-cultural themes emerged. First, colonisation imposed intergenerational trauma, displacing Indigenous fathers from nurturing roles and excluding them from maternity systems. Second, fathers across Australian Aboriginal, Nehiyaw (Cree), and Māori communities actively reclaimed traditional values of aroha, protection and emotional presence as acts of healing and resistance. Third, culturally grounded methodologies were essential to honour Indigenous epistemologies and amplify fathers' voices authentically.

Conclusion: Indigenous fathers are not absent from the birthing space by choice but by systemic exclusion. Midwives who build trust, facilitate cultural connections, and create father-inclusive environments can support whānau healing and identity reclamation.

Key message: Engaging tāne as active partners in care, upholding Te Tiriti principles, and challenging colonial constructs of gender strengthens whānau wellbeing and advances equitable, culturally safe maternity practice.

Development of a 3D learning tool for cervical assessment

Melanie Welfare[A,B], Shelley Stuart[C], Michelle Gray[D]

[A] Presenting author: mpwelfare@hotmail.com
[B] Ara Institute of Canterbury | Ara Rau, Taumata Rau
[C] Edith Cowan University, Australia
[D] University of Newcastle, Australia

Background: Understanding cervical movement and change during early labour, including the shift from a posterior retroverted to a central or anterior position, cervical effacement, dilatation and descent of the fetal head, remains challenging for midwifery students. These concepts are abstract, difficult to visualise, and not easily conveyed through text and static diagrams. While 3D animation has the potential to enhance comprehension, few pedagogically grounded resources exist to support students' learning of these complex physiological processes.

Aim: To create an educational resource that assists students to understand cervical movement, dilation and descent of the fetal head during early labour.

Method: A Participatory Action Research (PAR), guided by the 7C's Feekery framework, was used to ensure a collaborative and iterative development of the resource. Students and educators participated as co-researchers, identifying learning challenges, conceptualising solutions, and reviewing the prototype materials. Focus groups were conducted via Microsoft Teams, recorded, and analysed using descriptive qualitative analysis to inform the refinement of the resource.

Findings: The final product is a PowerPoint-based learning resource incorporating 2D images and bespoke 3D animations that simulate pelvic anatomy and cervical physiology in early labour. Co-researchers reported that the animations improved clarity, supported visualisation of cervical change, and enhanced understanding of the relationship between anatomy and the descent of the fetal head. Embedding the content within a narrative case-scenario of a woman in early labour further strengthened students' ability to integrate physiological knowledge with holistic, woman-centred care.

Conclusion: The resource offers a low-tech, accessible teaching tool that can be delivered synchronously by educators without specialised technical skills, or accessed asynchronously by students within the learning management systems. It addresses persistent conceptual challenges in midwifery education by transforming abstract physiological processes into an engaging, comprehensive visual learning experience.